



Johns Hopkins HealthCare Provider Information Update Form

Fax to Provider Relations – 410-424-4604 for Questions please call 1-888-895-4998

Practitioner or Facility Change Information Add Information

Effective Date of Change _____

EHP Priority Partners PAC US Family Health Plan Hopkins Elder Plus

Practitioner Demographic Information

Last Name: _____ First Name: _____ MI: _____ Title: _____

Birth Date: _____ NPI: _____ Guard Status: _____

Medicaid #: _____ Gender: _____

Facility Demographic Information

Facility Name: _____

NPI: _____ Taxonomy: _____

If more lines are required, please use &/or copy page two.

Contact Person: _____ Phone: _____

Email: _____ Fax: _____

Practitioner Specialty Information

Primary Care Provider Yes No Specialty: _____

Accepting New Patients: Yes No
Age limits: _____ Specializing In: _____

Specialty Care Provider Yes No Specialty: _____

Specializing In: _____ Limited To: _____

Board Certification: _____ Certification Date: _____

Facility Specialty Information

Type of Facility: Laboratory Radiology ASC Hospital SNF Hospice Home Health Dialysis

OTHER: _____

List special services: _____

List service area you cover: _____

Practitioner Affiliations

List the Physician / Hospital Organizations you participate with: _____

Primary Admitting Facility: _____

Additional Admitting Facilities: _____

Billing Information-MUST Attach W-9

Billing Name: _____

Tax ID#: _____ Group NPI or Taxonomy# _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____ Contact Person: _____

Address Information

Primary Location

Office Hours: To & From

Practice / Group Name :	Monday _____
Building Name:	Tuesday _____
Street Address:	Wednesday _____
Suite Number:	Thursday _____
County:	Friday _____
City, State, Zip:	Saturday _____
Telephone Number:	Sunday _____
Fax Number:	If office hours are left blank the 9am to 5pm default will be entered
Contact Person:	
MA Number :	Mailing Address: <input type="checkbox"/> Yes <input type="checkbox"/> No
*Languages Spoken by Provider:	
*Languages Spoken by Office Staff:	

Additional Addresses:

Office Hours: To & From

Practice / Group Name :	Monday _____
Building Name:	Tuesday _____
Street Address:	Wednesday _____
Suite Number:	Thursday _____
County:	Friday _____
City, State, Zip:	Saturday _____
Telephone Number:	Sunday _____
Fax Number:	If office hours are left blank the 9am to 5pm default will be entered
Contact Person:	

