Provider Information Update Form

Email: ProviderChanges@jhhc.com

Questions? Call Provider Relations at 1-888-895-4998

Johns Hopkins Healthcare is dedicated to maintaining an accurate and up-to-date provider directory. Provider Information Change Notification must be made at least thirty (30) days in advance of the change in writing or using this form.

Complete this form with all current information. Send completed form along with your W-9 to Provider Relations via the above email address. **PLEASE NOTE: IF USING A SOCIAL SECURITY # IN PLACE OF A TAX ID, THIS COMPLETED UPDATE FORM MUST BE FAXED TO 410-424-4604 TO ENSURE IDENTITY PROTECTION.**

☐ **Check here to indicate there are no changes at this time.**

PRODUCT: ☐ **EHP** ☐ **USFHP** ☐ **PPMCO** ☐ **Advantage MD** ☐ **ElderPlus**	
TODAY'S DATE:	**Effective Date of Change:**
Provider Information: ☐ **New** ☐ **Change** ☐ **Remove** ***If Change, select all that apply*** ☐ **Name** ☐ **Specialty** ☐ **Panel**	
Provider Name:	
New Name:	
Type I NPI:	CAQH Number:
Specialty:	Is Provider a Primary Care Physician: ☐ Yes ☐ No
New Specialty:	**Board Certified in Specialty:** ☐ **Yes** ☐ **No** ***If Yes, attach copy of board certification***
Panel Status: ☐ **Open Panel** ☐ **Close Panel**	**Reason for Panel Change:**
Provider Leaving Practice: ☐ **Moved Out of Area** ☐ **Retired** ☐ **Other:** ☐ **Joining Another Practice** ☐ **Deceased**	
Practice Information: ☐ **New** ☐ **Change** ☐ **Remove** ***Type of Change*** ☐ **Name** ☐ **TAX ID** ☐ **NPI** ☐ **Email or Contact**	
Practice Name:	Email:
Tax ID:	Type II NPI:
Contact Name:	Contact's Phone Number:
New Name:	**New Email:**
New Tax ID:	**New Type II NPI:**
New Contact Name:	**New Contact Phone Number:**
Address Information: ☐ **New** ☐ **Change** ☐ **Remove** ***Type of Location*** ☐ **Practice** ☐ **Mailing/Corres.** ☐ **Vendor/Billing**	
Address:	
Phone:	Fax:
Address Information: ☐ **New** ☐ **Change** ☐ **Remove** ***Type of Location*** ☐ **Practice** ☐ **Mailing/Corres.** ☐ **Vendor/Billing**	
Address:	
Phone:	Fax:
Authorized Signature	
Person authorized to make change (Print):	Email:
Signature:	Title: / Date: