

# **VIRGINIA PREMIER HEALTH PLAN PROVIDER UPDATE REQUEST FORM**

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## **Update Request**

Address change     Additional location     Add provider to existing group     Tax ID change

Termination    Termination Date: \_\_\_\_\_

Term Reasons:     Resigned     Retired     Relocated     Contract issues     Closed Office

Effective Date: \_\_\_\_\_

Other updates: \_\_\_\_\_

## **Provider Information**

Provider Name: \_\_\_\_\_

Degree: \_\_\_\_\_    SSN: \_\_\_\_\_    DOB: \_\_\_\_\_    Male   
Female

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_    State: \_\_\_\_\_    Zip: \_\_\_\_\_

Phone No.: \_\_\_\_\_    Fax No.: \_\_\_\_\_

County: \_\_\_\_\_

PCP     Specialist    Specialty: \_\_\_\_\_

Board Certified?     Yes     No    Board Name: \_\_\_\_\_

Board Cert Initial Date: \_\_\_\_\_    Board Cert Expiration Date: \_\_\_\_\_

Language \_\_\_\_\_    Network (if applicable): \_\_\_\_\_    Individual NPI # \_\_\_\_\_

License# \_\_\_\_\_    License Expiration Date: \_\_\_\_\_

DEA # \_\_\_\_\_    DEA Expiration Date: \_\_\_\_\_

Tax ID #: \_\_\_\_\_

Group NPI # \_\_\_\_\_

Accepting New Patients?    Yes     No

Active full Hospital Privileges? Yes  No

Hospital: \_\_\_\_\_