

PROVIDER CHANGE FORM



CURRENT PRACTICE INFORMATION

Group Practice Name/Individual Name: _____
(Please Circle One ↑)

Group Practice ID/Individual ID: _____ KF ID: _____ NPI # _____ PPID# _____
(Please Circle One ↑)

Contact Person Name (please print clearly) _____ Telephone _____ Fax _____ e-mail address _____

Authorizing Signature (physician/office manager) _____ Today's Date _____ Effective Date of Change _____
Change will not be completed without signature

PROVIDER CHANGE INFORMATION

Provide Complete Information – This Request will be processed for Keystone First. If any of these changes result in a change on your W-9, you must submit a copy of your W-9 with this change form. PLEASE NOTE: Practitioners must complete Keystone First Credentialing before they will be added to your practice as a participating provider. Refer to the Keystone First website for Credentialing Requirements: www.keystonefirstpa.com.

Type of Change: Adding a Practice Adding an office location Fax change
(Please check all that apply) Joining a Practice Changing an office location Name change only
 Telephone change Other (attach documentation)

PREVIOUS OFFICE INFORMATION

Keystone First Group Provider ID _____ NPI _____
Name _____
Street Address _____
City _____ State _____ Zip _____

NEW OFFICE INFORMATION

Keystone First Group Provider ID _____ NPI _____
Name _____
Street Address _____
City _____ State _____ Zip _____

ADD Practitioners (New Practitioners must complete Keystone First Credentialing before they are added as a participating provider)

1. _____ NPI _____ PPID _____
Last First M.I. Degree

2. _____ NPI _____ PPID _____
Last First M.I. Degree

TERMINATE Practitioners (Please give Keystone First 60 days advance notice when a Practitioner is leaving the group)

1. _____ NPI _____ PPID _____
Last First M.I. Degree

2. _____ NPI _____ PPID _____
Last First M.I. Degree

BILLING LOCATION CHANGE

Street Address 1 _____ Telephone _____ Fax _____ e-mail address _____
Street Address 2 _____ Federal Tax ID (change in Federal ID requires new W-9) _____
Street Address _____
City _____ State _____ Zip _____

CHANGE OF OWNERSHIP

Legal Business Name of New Owner and Federal Tax ID (Requires new W-9) _____ Effective Date of Ownership _____

Please Mail or Fax this change form and supporting documents to:
Keystone First, Provider Network Management, 200 Stevens Drive, Philadelphia, PA 19113 Fax 215-937-5343