care n care
Insurance Company, Inc.

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cnchealthplan.com

Provider Update Form

Provider Update Form intent is to notify Care N' Care of demographic changes needed for active in-network contracted Providers.

Are you currently an active contracted Provider?
IF NO, please fill out the ***Join Our Network Form.***

Are you currently an active contracted provider accessing Care N' Care via an Independent Practice Association (IPA)?
IF YES, please contact your IPA Representative to make any changes with Care N' Care.

Do you need to:

- Add a new provider to an existing contracted group?
- Change a Tax Identification Number (TIN) for an existing contracted provider or group?
- Terminating an active provider or group?

IF YES, please email Contracting Department with your details at:
Contracting@cnchealthplan.com

Are you a Group, Ancillary/Facility Provider, or Individual Provider?

Choose Option Below:

Group: Fill out the red Group Provider Update Form.

Ancillary/Facility Provider: Fill out the yellow Ancillary/Facility Provider Update Form.

Individual: Fill out the blue Individual Provider Update Form.

Provider Update Form: Group

Group DBA Name:	Group Legal Name:
Group Tax ID:	Group NPI:
Contact Name:	Contact Phone:
Contact Email:	

Reason for Request:

- □ Add Primary Location
- □ Add Additional Location
- □ Terminate Primary Location
- □ Terminate Additional Location
- □ Change Billing/Remit Address (W9 required)
- □ Change Mailing/Correspondence Address
- □ Change Point of Contact Information
- □ Change Panel Status (i.e. New Patients)
- □ Change Directory Status (i.e. Directory Print Display)

Effective Date:

Primary Practice Location: □ Yes □ No			
Primary Practice Address:			
City:	County:	State:	Zip:
Phone:	Fax:		
Office Hours:			

Additional Practice Locations (If Any):

Practice Name:			
Secondary Practice Location: □ Yes □ No			
Secondary Practice Address:			
City:	County:	State:	Zip:
Phone:	Fax:		
Office Hours:			

Billing Address (W9 is Required for Change Billing/Remit Address along with this form)

Billing Address:			
City:	County:	State:	Zip:
Phone:		Fax:	

Mailing Address

Mailing Address:			
City:	County:	State:	Zip:
Phone:		Fax:	

Provider Update Form: Ancillary/Facility Provider

Ancillary/Facility DBA Name:	Ancillary/Facility Legal Name:
Ancillary/Facility Tax ID:	Ancillary/Facility NPI:
Contact Name:	Contact Phone:
Contact Email:	

Reason for Request:

- □ Add Primary Location
- □ Add Additional Location
- □ Terminate Primary Location
- □ Terminate Additional Location
- □ Change Billing/Remit Address (W9 required)
- □ Change Mailing/Correspondence Address
- □ Change Point of Contact Information
- □ Change Panel Status (i.e. New Patients)
- □ Change Directory Status (i.e. Directory Print Display)

Effective Date:

Primary Practice Location: □ Yes □ No			
Primary Practice Address:			
City:	County:	State:	Zip:
Phone:	Fax:		
Office Hours:			

Additional Practice Locations (If Any):

Practice Name:			
Secondary Practice Location: □ Yes □ No			
Secondary Practice Address:			
City:	County:	State:	Zip:
Phone:	Fax:		
Office Hours:			

Billing Address (W9 is Required for Change Billing/Remit Address along with this form)

Billing Address:			
City:	County:	State:	Zip:
Phone:		Fax:	

Mailing Address

Mailing Address:			
City:	County:	State:	Zip:
Phone:		Fax:	

Provider Update Form: Individual

Reason for Request:

- □ Add Primary Location
- □ Add Additional Location
- □ Terminate Primary Location (corresponding ADD Primary Location should be included)
- □ Terminate Additional Location
- □ Change Billing/Remit Address (W9 required)
- □ Change Mailing/Correspondence Address
- □ Change Point of Contact Information
- □ Change Panel Status (i.e. New Patients)
- □ Change Directory Status (i.e. Directory Print Display)

Effective Date:			
Last Name:	Primary Specialty:		TIN:
			NPI:
Suffix (SR, II):	Secondary Specialty:		CAQH#:
First Name:	PCP: □ Yes □ No		Medicare#:
Middle Name:	Accepting new patients: □ Yes □ No		
Degree (MD/DO):	Printing in Directory: □ Yes □ No		
Practice Name:			
Primary Practice Location: □ Yes □ No			
Primary Practice Address:			
City:	County:	State:	Zip:
Phone:	Fax:		
Office Hours:			

Additional Practice Locations (If Any):

Practice Name:			
Secondary Practice Location: □ Yes □ No			
Secondary Practice Address:			
City:	County:	State:	Zip:
Phone:	Fax:		
Office Hours:			

Billing Address (W9 is Required for Change Billing/Remit Address along with this form)

Billing Address:			
City:	County:	State:	Zip:
Phone:		Fax:	

Mailing Address

Mailing Address:			
City:	County:	State:	Zip:
Phone:		Fax:	

Comments:

Office Manager Contact Information:

Name:_____

Phone number:_____

Email:_____

Signature & Authorization

I acknowledge that the information provided and attached is accurate. I am an authorized representative on behalf of the practice to submit this request. I comprehend any false information will be reported back to the provider practice, Care N' Care Compliance and appropriate Care N' Care departments.

Contact Person filling out this form:

Print Name: _____

Signature: _____

Title:_____

Email: _____

Phone: _____

Date: _____

Completed Provider Update Form and W9 as applicable can be emailed to Provider Concierge at *providerconcierge@cnchealthplan.com* or by fax at 682-503-5427.

Please allow 45 business days for the provider updates to reflect our systems.