CENTER CARE

REQUEST FOR PROVIDER UPDATE

Provider Name		NPI		Tax ID of Group Requesting Change	
Will provider be seeking enrollment with Aetna Better Health of Kentucky?				☐Yes ☐No	

If Yes, Center Care provides credentialing services for Aetna Better Health of Kentucky and will notify Aetna upon completion of provider's credentialing, if applicable.

I. REASON FOR SUBMISSION (select all that apply)

Add	Group Changes	Term
☐ Add Billing Address	☐ Change Billing Address	☐ Term Group
☐ Add Billing Fax #	☐ Change Billing Fax #	☐ Term Location
☐ Add Billing Phone #	☐ Change Billing Phone #	☐ Term Provider
☐ Add Physical Location Address	☐ Change Group Name	**Provider Demographic Changes** (or corrections)
☐ Add Physical Location Fax #	☐ Change Location Address	☐ Change Name: ☐ Last ☐First ☐Middle
☐ Add Physical Location Phone #	☐ Change Location Fax #	☐ Change Individual NPI
☐ Add Correspondence Address	☐ Change Location Phone #	**Individual or Group-Level Change**
☐ Update Hospital Affiliation	☐ Change TIN	☐ Change applies to this provider only
☐ Update Covering Arrangements	☐ Change Group NPI	☐ Change (or info) applies to entire group

☐ If group or address is to be termed, please indicate term info on page 2, Section F.
☐ If new address is a billing address, fill out Group Name, TIN, and Pay To/Billing Address section at the bottom.
☐ If new address is a correspondence address, fill out address section at the top.

Eff Date of Change

II. NEW ADDRESS INFORMATION

A. Address Info — If provider does not accept patient appointments at location, please indicate as "Covering Only" or Hospital-based ("HB"), as applicable. Hospital-based (HB) locations, Covering Only locations, and locations where provider does not see patients at least 16 hours per week will be suppressed from directory. If covering arrangements have changed, see page 2, section I.

☐ Primary Office ☐ Alternate Office ☐ Covering Only ☐ HB Address ☐ Billing Address ☐ Correspondence Address

Group Name			TIN

Address Line 1	Address Line 2	Phone	Fax

City	State	Zip	Group NPI

CLIA Number ☐N/A	CLIA Exp	If location is not primary care, list scope of practice	Primary Hospital Affiliation or Covering Arrangements

Location-Specific Info (N/A if above is Billing/Correspondence)	Y	N	Location-Specific Info (N/A if above is Billing/Correspondence)	Y	N
Does practice offer lab services at this site? (CLIA Required)			Is address handicap accessible?		
Is provider at this site at least 16 hours per week?			Is address TDD hearing (text telephony) equipped?		
Can patients call this site to make appointment with provider?			Is address accessible by bus route?		
Is provider accepting new patients at this site?			Does practice provide American Sign Language services at this site?		
Is provider a PCP at this site?			Does provider provide telemedicine services at this site?		
Does provider provide EPSDT services at this site?			Does provider bill for DME services? (Provide sample claim)		
If PCP, is provider's panel open at this site for Medicaid?			Does this site participate in KHIE?		
If PCP, is provider's panel open at this site for Medicare?			Is provider a locum tenens provider?		
What is the maximum panel capacity for Medicaid at this site?			Has provider completed cultural competence training?		
What is the maximum panel capacity for Medicare at this site?			Is provider certified in trauma-informed care (TIC)?		
What are the age limitations for patients seen?			Has provider been trained in evidence-based practice?		
Is there a gender restriction at this site? (If yes, please specify)					

Office Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Practice Website (for directory)	**Practice Email** (for directory)

Supervising Physician (NP/PA only)	**Supervising Physician Specialty**

B. Pay To/Billing Address	**City, State, Zip**	**Billing Phone**	**Billing Fax**

III. CHANGE INFORMATION

If more space is needed for the change being indicated, please use Notes section to provide all necessary details.

A. CHANGE TIN (Attach W9; see also Section E)		**B. CHANGE NPI**	☐Individual ☐Group
Previous TIN	New TIN	Previous NPI	New NPI

C. CHANGE PROVIDER NAME	Name Changing: ☐First Name ☐Middle Name ☐Last Name
Previous Name	New Name

D. CHANGE Number	Phone Number Change is for this Address:	☐Location ☐Billing	
Previous Phone Number	New Phone Number	Previous Fax Number	New Fax Number

E. CHANGE GROUP NAME	☐Legal name change only; no DBA change ☐Applies to all locations under TIN ☐Applies only to (please specify):	Applies to this address (or these addresses) only:
Previous Group (or Legal) Name		New Group (or Legal) Name

F. TERM INFORMATION	☐Term Provider	☐Term Address(es) (specify below)	☐Term TIN: (includes all locations)
Address to Term		Address to Term	
Address to Term		Address to Term	

G. CHANGE BILLING ADDRESS	New Pay To Name:		
New Billing Address	City, State, Zip	Billing Phone	Billing Fax

H. CHANGE in Specialty, Category, or Panel	Change in Panel:	☐Close Panel ☐Open Panel ☐Member Capacity	Panel change is for address:	Capacity:
☐ Update Primary Specialty		☐ Update Secondary Specialty		

☐ Change to PCP ☐ Change to SCP	at Address:

I. Update Hospital Affiliation or Covering Arrangements	☐ Update Covering Physician or Hospitalist Group:

☐ Update Primary Hospital Affiliation	Start Date	☐ Update Secondary Hospital Affiliation	Start Date

IV. UPDATE NOTES and CONTACT INFO

Notes	Include any other information that will help us process your change request correctly. For example, changes not indicated above (e.g., taxonomy change or use to indicate multiple addresses affected by a change).

Contact Name	**Phone**	**Email**