Parkland Community Health Plan

Provider Action Form

Complete this form to update PCHP network provider information. Email to PCHPProviderInfoUpdate@phhs.org

Action *Please check one or more as appropriate*		**Effective Date**
☐ Medicaid/TPI # Change for Service Location	☐ Provider Directory Changes	
☐ Medicaid/TPI # Change for Individual Provider	☐ Term Provider	
☐ Change Address / Phone (Billing / Mailing / Remit) *Attach W9*	☐ Remove Provider from Service Location	
☐ Change Address / Phone (Physical Service Location)	☐ Other *(please explain)* :	
☐ Add Address / Phone (Physical Service Location)		

Tax ID Add/Change? Email PCHP.ContractingDepartment@phhs.org.
Add Provider to existing contact or to Join PCHP? Complete the Prospective Provider Form and email to PCHP.ContractingDepartment@phhs.org.

Provider Information

Last Name	**First Name**	**MI**	**Degree**
Provider NPI #	**DOB**	**Provider Specialty**	**Practice as:** ☐ PCP ☐ Specialist
License #	**Tax ID #**	**Medicaid/TPI #**	

Physical Service Location

○ Primary Location ○ Secondary Location

Service Location Name:	**Service Location Website**	**Service Location Email**

Street Address			
City	**State**	**Zip Code**	**County**
Phone	**Fax**	**Handicap accessible?**	☐ Yes ☐ No

Billing / Mailing / Remit Information

Billing Name Information				**Group TIN**
Street Address				**Group NPI #**
City	**State**	**Zip Code**	**County**	**Medicaid/TPI #**
Phone	**Fax**	**Billing Email**		

Provider Term

Term Reason	**Assign Members to New Provider: Name**
Name of New Service Location for Members	**Assign Members to New Provider: NPI**

Provider Directory

Gender Restrictions	**Language**	**Appear in Directory**	**Accepting New Members**
		☐ Yes ☐ No	☐ Yes ☐ No

Age Range	**Telemedicine**	**Office hours for specified service location above:**	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	☐ Yes ☐ No								

Additional Comments

Requestor Name	**Date**	**Phone**	**Email**

Please submit to **PCHPProviderInfoUpdate@phhs.org**