Complete this practice change request form and send it to the CVO at cvochange@wellspan.org or fax to attention CVO Change at **717-851-6798** in order to process your request. Contact WellSpan Population Health Provider Relations **717-851-6800** for questions.

INDEPENDENT PRACTICE CHANGE REQUEST FORM

Type of change:

☐ **ADD** ☐ **CHANGE** ☐ **DELETE** ☐ **TERM**

What to change:

☐ **PROVIDER** ☐ **PRACTICE**

Effective Date of Change:_____TAX ID: _____

Name of Practice: _____

Group NPI: _____

Current practice address: _____

Is this location closing? Yes or No (circle if applicable)

Current Practice Location NPI: _____

New practice location: _____

New Practice Location NPI:_____

Name of Provider(s): _____

If provider is <u>leaving</u> your practice location(s), complete the following questions:

Please indicate where they are going _____

If <u>adding a physician extender</u> to a new location, please **<u>provide a copy</u>** of the collaborative agreement/prescriptive authority/written agreement update to show the physician at the location who will be supervising their work and who we will bill under for some plans

OTHER changes: (i.e. Age limits, phone or fax numbers, hours, managers)

_____

Practice Manager's name [PRINT]: _____

Practice Manager's Email Address:_____

Practice Manager's Phone and Fax # _____

Date:_____