INTEGRIS HEALTH Partners

Provider Add/Change Form

Instructions: Please enter required (*) information in the first section of this form. Check the appropriate box below and complete the corresponding section. Complete one form for each provider that needs updated.
If you are **Adding A Location** large group, enter "see attached list" in the name field. Then, you may attach a list of provide who will needed to be listed with this location.

Return to: IHPCredentialing@integrishealth.org

☐ **Add Provider** – request to add new provider to the IHP Network. If the provider does not have privileges at INTEGRIS, please complete the Participation Request Form.

☐ **Add a location** – request to add a location to an existing IHP provider.

☐ **Change Provider Information** – request to update information on a current location and/or provider.

☐ **Close Location –** request to close a location where services are no longer rendered.

Add Provider/Change Provider Information Please complete this section, send a W9, and malpractice certificate.			
*Name:			
*Medical Degree:		Specialty:	
Group Name (as listed on w9)			
DBA Name (as listed on w9)			
Office/Physical Address:		Mailing Address: (if different)	
Primary Telephone:		Primary Fax:	
Location Start Date: (This is for documentation purpose. This will not be provider's effective date.)		Languages Spoken:	
*Provider NPI:		EMR: (Please list which EMR you use)	
Tax ID: (for claims payment)		Tax ID: (for shared savings payment)	
Primary Email: (Provider)		Office Manager Name and Email:	
Credentialing Contact Name:		Credentialing Contact Email:	
Hospital Privileges:			
Office Hours:	Accepting New Patients? ☐ Yes ☐ No	Age Range of Patients:	PCP? ☐ Yes ☐ No
Is your practice on good standing with state and federal regulatory bodies? ☐ Yes ☐ No			Date of last survey:

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Add A Location

Add a location to an existing IHP provider or additional locations for a new provider.

Additional Locations Group Name:	Location Start Date: (This is for documentation purpose. This will not be providers start Date)	
Address of location:		
Tax ID: (for claims payment)	Tax ID: (for shared savings payment)	
Office Hours:	Age of Patients Accepted:	PCP: ☐ Yes ☐ No
Is your practice on good standing with state and federal regulatory bodies? ☐ Yes ☐ No		Date of last survey:

Additional Locations Group Name:	Location Start Date: (This is for documentation purpose. This will not be providers start Date)	
Address of location:		
Tax ID: (for claims payment)	Tax ID: (for shared savings payment)	
Office Hours:	Age of Patients Accepted:	PCP: ☐ Yes ☐ No
Is your practice on good standing with state and federal regulatory bodies? ☐ Yes ☐ No		Date of last survey:

Close Location

Location where services are no longer rendered.

Name of location:	End date of location:
Address of location:	

Name of location:	End date of location:
Address of location:	

Attestation:	
Form Completed By:	Title:
Date:	