INFORMATION UPDATE

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UPHP
UPPER PENINSULA HEALTH PLAN

Complete only the sections in which the provider's status has changed since the last credential date, reappointment date, or the most recent update. Please be sure to fill in the ***Effective Date*** and ***Personal Information*** sections of this form. If you have any questions, you may call *UPHP* at ***(906) 226-4285*** or contact your department administrator or office manager.

Effective Date (MM-DD-YY):	**Reason for update:** ❑New, Locum provider	❑New, hospital only provider	❑ Updating existing information, adding additional location(s)	❑Terming existing information, adding new location(s)

Special Instructions/Comments:

PERSONAL INFORMATION

Completion of this section required.

Last Name	First Name	MI	Degree	Provider NPI #
Employer	Provider Email Address	Medicare: ❑Enrolled ❑In process of enrolling ❑Do not plan on enrolling		
Contact Name	Contact Phone #	Contact Fax #	Contact Email Address	

PRACTICE LOCATIONS

❑Provider is not a PCP

– or –

❑Provider is a PCP and:

- ❑Accepts assigned Members
- ❑Accepts auto Assigned members
- ❑No longer accepts Assigned members
- ❑No longer accepts auto assigned members

Primary Practice Location / Name			Start Date	Location Specialty
Address	City	State ZIP		County
Phone #	FAX #	Federal Tax ID #	Practice Hours	Provider's Hours Per Week ❑>20 hours ❑<20 hours
Office Manager Name		Office Manager Email Address		
Provider's supervising physician		Service Location NPI		

Secondary Practice Location / Name			Start Date	Location Specialty
Address	City	State ZIP		County
Phone #	FAX #	Federal Tax ID #	Practice Hours	Provider's Hours Per Week ❑>20 hours ❑<20 hours
Office Manager Name		Office Manager Name		
Provider's supervising physician		Service Location NPI		

Other Practice Location / Name			Start Date	Location Specialty
Address	City	State ZIP		County
Office Manager Name	Office Manager Email Address		Service Location NPI	

BILLING INFORMATION

Please provide the exact information that will be submitted on claims.
Any information that is incorrect will result in claim denials.

Payee Name		Group NPI #
Address	City	State Zip Code
Phone #	FAX #	Federal Tax ID #

LICENSURE AND REGISTRATION

Please provide a copy of the State License for the location(s) listed above. If the provider is practicing in more than one state (i.e. WI and MI), a copy of each must be on file with UPHP.

PROFESSIONAL LIABILITY INSURANCE

Please submit a copy of the face sheet of the liability insurance for the above facility.

If changes other than above have been made since this provider's credential date, reappointment, or latest update please be sure to notify UPHP by submitting the information on another sheet. ***An authorized representative may sign below, but please give your full name and title.***

I, _____ attest that all changes and or updates requested herein, to the best of my knowledge, are true and correct.
Provider Name (print)

_____ _____
Signature of Provider or Authorized Representative **Date**