

INFORMATION UPDATE

MAIL: 853 West Washington Street, Marquette, MI 49855 FAX: (906) 225-1087 EMAIL: uphpproviderrelations@uphp.com



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:	<input type="checkbox"/> New, Locum provider	<input type="checkbox"/> New, hospital only provider	<input type="checkbox"/> Updating existing information, adding additional location(s)	<input type="checkbox"/> Termining existing information, adding new location(s)
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Special Instructions/Comments:

PERSONAL INFORMATION <i>Completion of this section required.</i>	Last Name	First Name	MI	Degree	Provider NPI #
	Employer	Provider Email Address	Medicare: <input type="checkbox"/> Enrolled <input type="checkbox"/> In process of enrolling <input type="checkbox"/> Do not plan on enrolling		
	Contact Name	Contact Phone #	Contact Fax #	Contact Email Address	

PRACTICE LOCATIONS	Primary Practice Location / Name			Start Date	Location Specialty		
	Address		City	State	ZIP		
	County						
	<input type="checkbox"/> Provider is not a PCP – or –	Phone #	FAX #	Federal Tax ID #	Practice Hours	Provider's Hours Per Week <input type="checkbox"/> >20 hours <input type="checkbox"/> <20 hours	
	<input type="checkbox"/> Provider is a PCP and:	Office Manager Name		Office Manager Email Address			
	<input type="checkbox"/> Accepts assigned Members	Provider's supervising physician			Service Location NPI		
	<input type="checkbox"/> Accepts auto Assigned members	Secondary Practice Location / Name			Start Date	Location Specialty	
	<input type="checkbox"/> No longer accepts Assigned members	Address		City	State	ZIP	
	<input type="checkbox"/> No longer accepts auto assigned members	County					
		Phone #	FAX #	Federal Tax ID #	Practice Hours	Provider's Hours Per Week <input type="checkbox"/> >20 hours <input type="checkbox"/> <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. <u>Any information that is incorrect will result in claim denials.</u>				
	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