GOLD KIDNEY HEALTH PLAN

PROVIDER INFORMATION CHANGE FORM

Practice/Facility Name as Currently Listed in Provider Directory:	**County:**	**Billing NPI #**	
Street:	City:	State:	Zip:

Instructions: Please indicate the type of change you would like to make and complete all the information in the corresponding section of the form.

☐ Change Practice Name, Address, Phone, or Fax – Section A ☐ Change Tax ID or NPI - Section B ☐ Change Pay To information – Section C
☐ Change Member Assignment (PCP Only) – Section D ☐ Change Office Hours – Section E
☐ Change Information for an Individual Practitioner (name, employment status, location, languages spoken) – Section F

To add a NEW PRACTITIONER or NEW LOCATION, please contact Credentialing at providerrelations@goldkidney.com to initiate the process.

This form will be considered incomplete and will delay processing if information, and/or an effective date and signature are missing.

A. Practice Information: Check all that apply and provide information requested

☐ **Change Practice Name to:**				
☐ **Change Service Location to:**	Street:	City:	State:	Zip:
☐ **Change Telephone # to:**		☐ **Change Fax # to:**		

B. Change of Taxpayer Identification Number (TIN) or National Provider Identifier (NPI)

☐ **Change TIN from:**	Old#	**to:**	New#	* A new W-9 Must be attached for change to be processed
☐ **Change NPI from:**	Old#	**to:**	New#	* Proof of Medi-Cal Must be attached for change to be processed

C. Change Pay to Address: Changes that directly impact the issuance of your 1099 requires the submission of a NEW W-9 with this form

New Pay To Address	Street:	Suite #:
City:	State:	Zip:
Phone:	Fax:	Effective Date:

D. Change to Member Assignment (select one) For PCPs Only

☐ **Accepting New Patients:** In addition to your current patients, new Gold Kidney members and members who are selecting a new provider can select your practice without restrictions ☐ 65 – 99 years

☐ **Accepting New Patients With Auto-Assignments:** In addition to your current patients, new Gold Kidney members may select your practice and/or PHC members who have not selected a Primary Care Physician (PCP) may be assigned automatically to your practice based on zip code.

☐ **Accepting Existing Patients**: Gold Kidney members who have an existing or past relationship with your office can request to be assigned to your practice. Members who lose and then regain eligibility are automatically re-linked to their last PCP. For any exception, Gold Kidney must receive verbal or written approval from your office prior to assigning the patient to your practice.

☐ **Not Accepting New Patients:** Practice closed to all **new** Gold Kidney members.

E. Change of Office Hours: indicate when a patient can call to make an appointment e.g., 8am – 5pm (Lunch Hour Not Listed in Directory)

Select CLOSED if closed for the full day only

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
____ ☐ AM ☐ PM To ____ ☐ AM ☐ PM ☐ Closed	____ ☐ AM ☐ PM To ____ ☐ AM ☐ PM ☐ Closed	____ ☐ AM ☐ PM To ____ ☐ AM ☐ PM ☐ Closed	____ ☐ AM ☐ PM To ____ ☐ AM ☐ PM ☐ Closed	____ ☐ AM ☐ PM To ____ ☐ AM ☐ PM ☐ Closed	____ ☐ AM ☐ PM To ____ ☐ AM ☐ PM ☐ Closed	____ ☐ AM ☐ PM To ____ ☐ AM ☐ PM ☐ Closed

F. Change Information for an Individual Practitioner within your organization:

Practitioner Name:	**Title:**

Change in Employment Status or Location within your organization: (check one)

☐ **Retired** – Effective Date:

☐ **Termed Employment/Resigned** – Effective Date:

☐ **Moved or Added Additional Site(s)** – Effective Date: ____________

Check the Appropriate Box below for Moving an individual Provider and Complete ALL Applicable Information.

☐ The Provider has moved from one site to another within your organization

Remove Provider from Directory Listing at this location: ______________________________

Add Provider to Directory Listing(s) at this location: ______________________________

☐ The Provider is rendering services at an additional location(s) within your organization

List locations within the directory to include this provider: ______________________________

Change Languages Spoken by Practitioner: Please use this section to make any language corrections necessary for the directory

☐ Add:	☐ Delete:

Change Practitioner Name: Please use this section to make any spelling corrections necessary for the directory

Current Spelling:	Correct Spelling:

Plan Notification: Per your agreement, the Plan must be notified in writing of any significant changes in the **availability or location** of covered services, or any significant change in information. (e.g. change of address, phone number, or office hours)

Was Gold Kidney notified of the change(s) represented on this form?

☐ **Yes -** Please attach a copy of the notification ☐ **No**

How were members notified? Choose one

☐ Mailed Letters to Gold Kidney

Explanation of Changes listed above:

Information Verification

I hereby affirm that the information submitted in this application is correct and complete to the best of my knowledge and belief, and is furnished in good faith.

☐ **Please process the changes listed above with the effective date of** __________

Printed Name of Person Completing Form: ____________________ Date: ____________________

Signature: ______________________________ Title: ____________________

Contact Email: ____________________ Contact Phone: ____________________

Return this form to the Provider Relations Department as directed below:
Return this by fax to 1 (866) 580-0122 Or email to providerrelations@goldkidney.com