Provider Change Form Instructions

Please reference the table below before completing this form. Please attach a W9 for all changes. Please use one form per change.

Facility/Provider = hospital, group, FQHC, RHC, etc.
Practitioner = MD, DO, ARNP, or other individual that works within a Facility/Provider location

EFFECTIVE DATE OF CHANGE

Changes must be received at least 30 days in advance so that the change may be made prior to a provider or practitioner seeing Sunflower members.

Change Type	Documents Required?	Email
I have a facility name and TIN change	Changes to a facility name and Tax ID (TIN) require a new Participating Provider Agreement and submission of credentialing materials.	A request for a new agreement may be made by going to: http://www.sunflowerstatehealth.com/for-providers/become-a-provider/contract-request-form/, check new contract and fill out the information requested.
I have a facility name or TIN change	A change to the facility name or a change in the TIN requires a contract amendment to the Participating Provider Agreement. An updated W9 will be required.	A request for an amendment to an existing agreement may be made by going to: http://www.sunflowerstatehealth.com/for-providers/become-a-provider/contract-request-form/, check amendment and fill out the information requested.
I wish to add another NPI and Service	New Credentialing Application is required. Facility/Provider's NPI may need to be enrolled on KMAP prior to adding the service. An email explaining the change would also be helpful to Sunflower.	Please complete and return all required documents in the Credentialing Application. To request a Credentialing Application, please email your request to the Contracting Department: **sunflowerstatehealth@centene.com**
I wish to change the current NPI and/or Service or end a Service (ending a Service may be done without terming the agreement)	New Credentialing Application is required. Facility/Provider's NPI may need to be enrolled on KMAP prior to changing the service. An email explaining the change would also be helpful to Sunflower.	Please complete and return all required documents in the Credentialing Application. To request a Credentialing Application, please email your request to the Contracting Department: **sunflowerstatehealth@centene.com**
Practitioner Add/Term/Change	Adds: Roster ***or*** CAQH Data Form Changes: Provider Change Form **Section E – change of provider status** Terms: Roster or Provider Change Form **Section E – change of provider status**	Please submit practitioner additions or terms on the approved Sunflower Health Plan roster Excel form or CAQH data form. Please note that a Disclosure of Ownership for stand-alone groups (not affiliated with a health system) and individual practitioners is required. To request a roster form or CAQH data form and Disclosure of Ownership form, please visit the Sunflower website at www.sunflowerhealthplan.com or email **sunflowerstatehealth@centene.com**
I have a Practitioner with a name change	Provider Change Form **and** Legal document such as Updated Medical License and Updated DEA - if available	Please complete and email both documents to the Sunflower Provider Relations Department: **sunflowerstatehealth@centene.com**
I wish to add/update an address – TIN is not changing	Provider Change Form For billing address changes please also submit an updated W9.	Please complete one of the following: **Section A – change physical address** **Section B – change/add second address** **Section C – change billing address** **Section D – change mailing address** email to the Sunflower Provider Relations Department: **sunflowerstatehealth@centene.com**
I wish to change my provider status	Provider Change Form	Please complete the following: **Section E – change of provider status** of the *Provider Change Form* and email to the Sunflower Provider Relations Department: **sunflowerstatehealth@centene.com**

Provider Change Form

Please complete this section for all changes listed below:

Today's Date:	Effective Date of Change:
Facility or Provider Legal Name:____	
DBA or Clinic Name (if applicable):	
TAX ID:	Medicaid#:
Group NPI#:	Taxonomy#:
Individual NPI#:	Facility Accreditation:
Licensure:	Contact Person:
State of Licensure:	Email Address:
Phone Number:	

Section A: CHANGE IN PHYSICAL ADDRESS, PHONE OR FAX

NOTE: Physical location will be included in provider directory; must be a street address (not a PO Box)

Previous Practice Location:	**New Practice Location:**
Facility/Provider Name:	Facility/Provider Name:
Address:	Address:
County:	County:
Phone #:	Phone #:
Fax:	Fax:
Contact Person:	Contact Person:
Email Address:	Email Address:
Medicaid #	Medicaid #
□ Term this Address	

Office Hours at this location? ☐ Open 24 hours - or complete hours of operations below:

MON	TUES	WED	THU	FRI	SAT	SUN

Section B: CHANGE or ADD OF SECOND LOCATION ADDRESS, PHONE OR FAX

Does the tax ID information change for this location? □ **YES** □ **NO**

If yes, contact the Sunflower Contracting Department at sunflowerstatehealth@centene.com

Facility/Provider Name:	
Second Location Address:	
County:	
Medicaid#	
Phone #:	Fax#:
Email Address:	Contact Name:

Office Hours at this location? ☐ Open 24 hours - or complete hours of operations below:

MON	TUES	WED	THU	FRI	SAT	SUN

Section C: CHANGE IN BILLING ADDRESS OR BILLING INFORMATION

Facility/Provider Name:	
New Billing Address:	
Phone #:	Fax #:
TAX ID#	
Exact name reported to the IRS for this Tax ID:	
Medicaid#	
Email Address:	Contact Name:

Section D: CHANGE IN MAILING ADDRESS

Facility/Provider Name:	
New Mailing Address:	
Phone #:	Fax #:
Email Address:	Contact Name:

Section E: CHANGE OF PROVIDER STATUS

Date change effective: ____

Type of change (i.e., terming from Sunflower network, addition of accreditation - please include copy of accreditation certificate, closing a location):

____

Explanation for the change: ____

____

____

____ _____________

Signature Date

(v 01.13.2015)