PROVIDER MAINTENANCE REQUEST FORM
FOR PCP, OB/GYN, PCP MID-LEVELS & OB/GYN MID-LEVELS

PROVIDER INFORMATION

PROVIDER NAME: _____

NPI: _____ DATE OF SUBMISSION: _____

EFFECTIVE DATE OF CHANGES:

NOTE: All Providers contracted with an IPA must notify the IPA of all changes according to contractual and policy requirements. IPAs remain responsible for providing timely notification (i.e., 60-day advanced notification for Providers with Members assigned) to IEHP of any Provider changes.

Maintenance Request (Check all that apply):

☐	ADDRESS (adding/terming a location or relocation)	☐	TIN CHANGE
☐	PROVIDER CHANGE (adding or terming a provider)	☐	PHONE, FAX, OR OFFICE HOURS
☐	AFFILIATION CHANGE (adding/terming an affiliation)	☐	CHANGE TO NON-PARTICIPATING PROVIDER (no Member Assignment)
☐	AGE LIMIT CHANGE	☐	OTHER:

Maintenance Request Applies to the following:

Provider Type	☐ PCP ☐ OB/GYN ☐ PCP Mid-Levels ☐ OB/GYN Mid-Levels:

PLEASE SEE THE BELOW CHECKLISTS AND INCLUDE REQUIRED DOCUMENTATION FOR EACH APPLICABLE MAINTENANCE REQUEST.

PCP, OB/GYN, PCP Mid-Levels, and OB/GYN Mid-Levels:

- **For W-9 changes, an updated W-9 form is required.**
- **For any IPA Changes, please attach new contract signature page and updated W-9 form.**
- **For Mid-Levels:**
  - **Malpractice Insurance**
  - **Nurse Practitioner Standard Procedures**
  - **Physician Assistant Delegation of Services Agreement (DSA)**
  - **Statement of Agreement**

Location(s) to be added and/or relocating to address **(please include Clinic Name)**:

Location(s) to be termed:

New Age Limit: _____

Old TIN: _____

New TIN: _____

New Phone: _____

New Fax: _____

New Hours: _____

Affiliation Change(s):

Changing to Non-Participating Provider:

Provider(s) to be TERMED: _____ Effective Date: _____

_____ Effective Date: _____

_____ Effective Date: _____

Provider(s) to be ADDED: _____ Effective Date: _____

_____ Effective Date: _____

_____ Effective Date: _____

Comments:

By signing below, I, *(Insert Provider Name)* _____ authorize IEHP to make said changes as noted on maintenance form:

Signature: _____ Date: _____

Please email completed form to ProviderUpdates@iehp.org or Fax to (909) 297-2502.