Changing Provider Enrollment Information

Requirement

All changes to provider enrollment must be made on a prospective basis. It is highly recommended that you use the Provider Change Form that outlines the required information and will help to expedite your request. The same procedures apply whether participation is with commercial or Medicare products. However, supplemental information may be required for providers participating in Medicare products.

Provider Number Guidelines

The following guidelines apply to provider numbers:

- A clinician with only one tax identification (Tax ID) number can only have one provider number.
- A clinician or group practice with more than one Tax ID number participating in more than one local care unit (LCU) must be enrolled in the Harvard Pilgrim claims system with a separate provider number for each Tax ID/LCU relationship.
- PCPs who have multiple provider numbers can only carry one member panel regardless of the number of provider IDs.
- Specialists with more than one Tax ID number who participate in more than one LCU must be enrolled in the Harvard Pilgrim claims system with a separate provider number for each Tax ID/LCU relationship.
- Providers are enrolled in Harvard Pilgrim's provider database consistent with their National Provider Identifier (NPI) and business relationships they establish with facilities, organizations, and clinicians included in the Harvard Pilgrim network.
- Facility and ancillary providers who have subparted by specialty or location, must notify Harvard Pilgrim of each NPI that will be submitted to Harvard Pilgrim by email at PPC@point32health.org.

Local Care Unit (LCU) Changes

Provider changes related to LCU affiliation include any one or combination of:

- Adding an LCU and provider number
- Terminating from an LCU
- Changing an LCU
- Terminating from Harvard Pilgrim

Notification Requirement

In all cases, a minimum of 60 days written notice to Harvard Pilgrim is required. To the extent that any provision of this Harvard Pilgrim Health Care manual is inconsistent with any provision of your contract with Harvard Pilgrim Health Care, the terms of the contract shall control.

Changes *Not* Related to LCU Affiliations

Changes not related to LCU affiliation may include any one or combination of:

- Practice address or practice name[1]
- Billing address
- Close member panel
- Addition or change to tax identification number (TIN)[1]
- Correct Harvard Pilgrim demographic information errors
- Change practice model to concierge style

Notification Requirement

In the cases noted above – with the exception of TIN addition/change and change to concierge model – 30 days written prospective notice to Harvard Pilgrim is required. For an addition or change to TIN, providers must provide written notice to Harvard Pilgrim 60 days in advance. If a practice is adopting a concierge style model, 90 days advance notice is required.

Medicare Participants

If you participate in our Medicare products and are making a change to your provider enrollment information, please notify us of your participation in the Medicare products. Harvard Pilgrim's Provider Change Form includes fields to note: your participation, National Provider Identified (NPI), TIN, Medicare numbers and LCU name (if applicable). If your practice is a messenger model, we will require additional documentation to confirm the participation status of individual practitioners. Please make certain that your change request includes this information.

Additionally, if you are part of a LCU in which only a portion of providers participate in the Medicare program, please confirm your participation with LCU leadership.

_____

[1] *Submission of a new W-9 form is required with practice name change and/or tax identification number change.*

Provider Change Form

Harvard Pilgrim Health Care
a Point32Health company

Complete ALL applicable information. Incomplete submissions may be returned unprocessed. NOT for new providers.

This form cannot be used to terminate your agreement in its entirety. Please refer to your agreement for details on your rights and obligations for termination of your agreement.

E-mail to: PPC@point32health.org
Fax to: 866-884-3843

Mail to: Harvard Pilgrim Health Care
Attn: Provider Processing Center
1 Wellness Way, Canton, MA 02021

Healthways Providers: www.healthways.com
or 800-327-3822

Please complete the applicable sections below to update your information.

Current Provider Information (*Section Required*)

Provider group practice name

Provider group practice email

Provider last name Provider first name

NPI # Individual Group

PTAN# (*if applicable*) Tax ID #

Provider type (*check all that apply*): PCP Specialist Dual Hospitalist

Moonlighter/Covering Only Ancillary/Allied/Mid-Level Locum Tenens

Is your facility handicap accessible? Yes No

Does the provider offer telehealth (i.e. office visits as well as virtual visits)? Yes No

Street

City State ZIP Phone

Indicate changes being submitted (*check all that apply*):

- Demographic change (name, address, NPI, practice status)
- LCU change
- Terminations

These changes apply to: Commercial Medicare Advantage

Indicate documents included:

- W9 (*required for any billing change*)
- Provider Roster (*required for changes impacting entire group*)
- Other:

Section I: Demographic Change — *30 Day Notice Required*

Effective date

New provider name:

Last name

First name

Enter **new additional addresses** below:

Old provider name:

Last name

First name

Addresses to be updated (*select one of the following actions*):

- Terminate location for this provider entirely from Harvard Pilgrim Health Care Provider Directory
- Provider to remain affiliated with this location but suppressed from listing in Harvard Pilgrim Provider Directory

CLEAR FORM

Provider name:

Address Type: Primary Secondary

Can patients make appointments to see this provider at this location? Yes No

Billing Mailing

Group Name:

Address line 1

Address line 2

City

State Zip

Phone

Provider name:

Address type: Primary Secondary

Billing Mailing

Group Name:

Address line 1

Address line 2

City

State Zip

Phone

Enter **new additional addresses** below:

Addresses to be updated (*select one of the following actions*):

Terminate location for this provider entirely from Harvard Pilgrim Health Care Provider Directory

Provider to remain affiliated with this location but suppressed from listing in Harvard Pilgrim Provider Directory

Provider name:

Address Type: Primary Secondary

Can patients make appointments to see this provider at this location? Yes No

Billing Mailing

Group Name:

Address line 1

Address line 2

City

State Zip

Phone

Provider name:

Address type: Primary Secondary

Billing Mailing

Group Name:

Address line 1

Address line 2

City

State Zip

Phone

NPI (*Please contact the Provider Service Center at 800-708-4414 if adding NPI for a subpart.*)

New Corrected

Practice Status (*May be impacted by contract terms and follow-up may be required.*):

Available to see new members

Available to see new members with a waitlist of 4 weeks or less

Close panel to all new members, but keep existing panel

Concierge practice (90 day notice required)

Other (*please specify*):

CLEAR FORM

Section 2: LCU Change — *60 Day Notice Required*

Effective date

Name of new or additional LCU:

Name of current LCU to be terminated (*if applicable*):

Add only

Name of new or additional hospital affiliation:

Name of current hospital affiliation to be terminated (*if applicable)*:

Add only Add & term

New or additional provider tax ID #

Tax ID # to be closed (*if applicable*)

New or additional provider payee #

Payee # to be closed (*if applicable)*

New or additional specialty or provider type change:*

**Please submit HCAS form for those specialties or provider types that require credentialing.*

Section 3: Terminations — *60 Day Notice Required*

This form cannot be used to terminate your agreement in its entirety. Please refer to your agreement for details on your rights and obligations for termination of your agreement.

Effective date

Reason for Termination (*select one*):

Resigned Deceased Practice closed Retired Moved out of state

Provider transferred to (*group name*):

Section 4: Contact Information — contact person submitting information (*Section Required*)

Name Title

Phone Email

Date of submission

CLEAR FORM