Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

PROVIDER CHANGE FORM

(PRIOR TO SUBMITTING THIS FORM, CHANGES MUST BE COMPLETED IN NCTRACKS)

Please complete this form for each service location. Trillium Health Resources will not assume a change is being made for the entire Agency/Practice unless explicitly noted.

Please complete any required actions that are applicable below *in red*. This form will be returned if required sections or supporting documents are missing or incomplete.

This form should not be used to request new service location additions or to add new services to a contract. Please email NetworkServicesSupport@TrilliumNC.org directly for these types of requests.

PROVIDER INFORMATION *(Required)*:

Provider Name		Effective Date MM / DD / YYYY	
NPI #		*Effective date cannot be prior to effective date in NCTracks*	
Address / Location			

COMPLETE THIS SECTION ONLY IF THERE IS A CHANGE (PLACE AN X IN THE APPROPRIATE CHECK BOX)

☐ **CHANGE IN KEY PERSONNEL (Ex. Main Contact, CEO, Director, Survey Contact, Information Change)**

☐ **ADD**

Name			
Address / Location			
Position		Effective Date MM / DD / YYYY	
Email			
Phone		Fax #	

☐ **DELETE**

Name			
Address / Location			
Position		Effective Date MM / DD / YYYY	
Email			
Phone		Fax #	

☐ **CHANGE OF SERVICE LOCATION (SITE)**

SITE TYPE ☐ **OFFICE** ☐ **UAFL**

Previous Site Address		County			
City		State		Zip+4	
Phone #		Fax #			
Email					
Office Hours					
Services Related to this Site					
Site End Date					

New Site Address		County			
City		State		Zip+4	
Phone #		Fax #			
Email					
Office Hours					
Services Related to this Site					
Site Effective Date					

☐ **REMOVE SERVICE LOCATION (SITE)** ***(Attach a request for removal on your letterhead)***

SITE TYPE ☐ **OFFICE** ☐ **UAFL**

Street Address		County			
City		State		Zip+4	
Phone #		Fax #			
Email					
Reason					
Services Related to this site					
Member Count for this Site/Services					

☐ **CHANGE IN BILLING LOCATION** ***(Include a copy of an updated W9)***

PREVIOUS BILLING LOCATION

Street Address		County			
City		State		Zip+4	
Phone #		Fax #			
Email					

NEW BILLING LOCATION

Street Address		County			
City		State		Zip+4	
Phone #		Fax #			
Email					
Office Hours					

☐ **CHANGE IN BED CAPACITY** ***(Update Registry of Unmet Needs in Provider Direct)***

From #		of Beds	→	To #		of Beds

☐ **CHANGE IN NPI**

Previous NPI		New NPI	

☐ **CHANGE IN INDIVIDUAL PROVIDER NAME**

Previous Full Name	
New Full Name	

☐ **CHANGE IN INDIVIDUAL PROVIDER TAX NAME**

Previous Tax Name	
New Tax Name	

☐ **CHANGE IN INDIVIDUAL TAX ID** ***(Include a copy of an updated W9)***

Previous Tax ID		New Tax ID / SSN	

☐ **TERMINATE MEDICAID PARTICIPATION** ***(Include a request for termination on your letterhead)***

☐ **Reason: Change in Ownership**

☐ **Reason: Other** ***(Please describe here)***

☐ **DELETION OF SERVICES PROVIDED** ***(Include a request for deletion of services on your letterhead)***

Service Code		End Date MM / DD / YYYY	
Service Code		End Date MM / DD / YYYY	
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Service Code		End Date MM / DD / YYYY	
Service Code		End Date MM / DD / YYYY	
Service Code		End Date MM / DD / YYYY	

Additional Comments / Instructions / Requests:

SIGNATURE IS REQUIRED FOR PROCESSING

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a provider.

Signature of Authorized Person | **Date**

Printed Name | **Title**

SUBMIT COMPLETED FORM BY EMAIL TO:

NetworkServicesSupport@TrilliumNC.org