

## PROVIDER CHANGE FORM

### PRIOR TO SUBMITTING THIS FORM CHANGES MUST BE COMPLETE IN NC TRACKS

Please complete a form for each individual site a change is needed to be made to. We will not assume a change is being made for the entire agency/practice unless explicitly noted. Please submit required items and needed attachments indicated *in red*. This form will be returned if required sections or supporting documents are missing.

Complete section information only if there is a change

### PROVIDER INFORMATION (REQUIRED)

Provider Name		Effective Date	mm	dd	yyyy
Medicaid Provider #		NPI #			
Address/Location					

### TYPE OF CHANGE - Please check the type of change

**CHANGE IN KEY PERSONNEL** (Main contact, CEO, Director, Survey Contact, Information Changes etc...)

#### 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			

**CHANGES FOR YOUR ENTRY ON TRILLIUM'S ONLINE DIRECTORY**

To obtain a Provider Directory Collection Form:

1. Go to [www.trilliumhealthresources.org](http://www.trilliumhealthresources.org)
2. Click on For Providers
3. Click on Network Provider Directory
4. Under Forms click on Provider Directory Collection Form
5. Complete form and submit to [TrilliumProviderDirectory@TrilliumNC.org](mailto:TrilliumProviderDirectory@TrilliumNC.org)

**ADD NEW (SITE) LOCATION                      Office                      UAFL**

Street Address		County			
City		State		Zip+4	
Phone #		Fax #			
Email					
Office Hours					
Licensed Site	<input type="checkbox"/> YES <i>(attach copy of license)</i> <input type="checkbox"/> NO				

**PREVIOUS (Site) Location                      Office                      UAFL**

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

**REMOVE OFFICE (SITE) LOCATION**

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

**NEW BILLING LOCATION *(Include a copy of updated W9)***

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

**PREVIOUS BILLING LOCATION**

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

**CHANGE IN BED CAPACITY** *(Attach state license reflecting bed capacity change; please update Registry of Unmet Needs in Provider Direct)*

From #		Beds	To #		Beds
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**Delete a Clinically Licensed Practitioner** *(MD, PA, FNP, LCSW, etc.)*

To obtain a form to delete a Clinically Licensed Practitioner:

1. Go to [www.trilliumhealthresources.org](http://www.trilliumhealthresources.org)
2. Click on For Providers
3. Click on Provider Documents and Forms
4. Under Credentialing click on Removal of a Clinically Licensed Practitioner
5. Complete form and submit to [Credentialing@TrilliumNC.org](mailto:Credentialing@TrilliumNC.org)

**NPI** *(Attach copy of NPPES reflecting NPI change)*

Previous NPI		New NPI	
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**Individual Provider Name** *(Attach copy of new license or certification reflecting name change)*

Previous Full Name	
New Full Name	

**Individual Provider Tax Name** *(Attach copy of new license or certification reflecting name change)*

Previous Tax Name	
New Tax Name	

**Individual Tax ID** *(Attach copy of your up-to-date W-9)*

Previous Tax ID		New Tax ID/SSN	
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**Change in Provider Specialty** *(Attach new license and letter requesting new specialty)*

New Specialty	
New Specialty	
New Specialty	

**Terminate Medicaid Participation** *(Attach request for termination on your letterhead)*

<input type="checkbox"/> Due to Change in Ownership
<input type="checkbox"/> Due to Other (Describe)

**Deletion of Services Provided** *(List each service code and the end date)*

Service Code		End Date	mm	dd	yyyy
Service Code		End Date	mm	dd	yyyy
Service Code		End Date	mm	dd	yyyy
Service Code		End Date	mm	dd	yyyy

**SIGNATURE IS REQUIRED FOR PROCESSING**

**Additional comments/instructions/requests:**

**SIGNATURE**

**SIGNATURE (REQUIRED)**

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

\_\_\_\_\_  
Signature of Authorized Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

**SUBMIT COMPLETED FORM BY EMAIL TO:**

Network Monitoring at:  
[NetworkMonitoring@TrilliumNC.org](mailto:NetworkMonitoring@TrilliumNC.org)