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

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
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

☐ ADD NEW (SITE) LOCATION ☐ Office ☐ UAFL

Street Address		County	
City		State	Zip+4
Phone #		Fax #	
Email			
Office Hours			
Licensed Site	☐ YES *(attach copy of license)* ☐ 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

☐ **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
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

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

Previous NPI		New NPI	

☐ **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	

☐ **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)*

☐ Due to Change in Ownership
☐ 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