

# PROVIDER UPDATE / CHANGE FORM



This form should be used when changing a practitioner or provider name, location, phone or fax number, billing or email address, and office hours. Please email or mail to Chorus Community Health Plans.

- Email to: [cchp-providerupdates@chw.org](mailto:cchp-providerupdates@chw.org)
- Mail to: CCHP Provider Relations  
P.O. Box 1997, MS 6280  
Milwaukee, WI 53201-1997

Type of change: \_\_\_\_\_

Effective date of change: \_\_\_\_\_

## SECTION 1: OLD INFORMATION (Note: Changes for practitioners and/or providers through a group must be submitted by the group.)

NAME OF ORGANIZATION (INCLUDE LEGAL NAME DOING BUSINESS AS)		FEDERAL TAX ID NUMBER	GROUP NPI 2	INDIVIDUAL NPI
<b>PHYSICAL ADDRESS</b>				
STREET ADDRESS		CITY	STATE	ZIP
PHONE NUMBER		FAX NUMBER		
<b>MAILING ADDRESS</b>				
STREET ADDRESS		CITY	STATE	ZIP
PHONE NUMBER		FAX NUMBER		
<b>BILLING ADDRESS</b>				
ADDRESS		CITY	STATE	ZIP
PHONE NUMBER		FAX NUMBER		

## SECTION 2: NEW INFORMATION (Only complete all the fields of item that has changed.)

NAME OF ORGANIZATION (INCLUDE LEGAL NAME DOING BUSINESS AS)		FEDERAL TAX ID NUMBER (TIN)	GROUP NPI 2	INDIVIDUAL NPI
<b>PHYSICAL ADDRESS</b> <input type="radio"/> <b>UNCHANGED</b>				
STREET ADDRESS		CITY	STATE	ZIP
PHONE NUMBER		FAX NUMBER		
<b>MAILING ADDRESS</b> <input type="radio"/> <b>UNCHANGED</b> (ONLY COMPLETE IF YOU'RE NOT ABLE TO ACCEPT MAIL AT YOUR PHYSICAL ADDRESS)				
STREET ADDRESS		CITY	STATE	ZIP
PHONE NUMBER		FAX NUMBER		
<b>BILLING ADDRESS</b> <input type="radio"/> <b>UNCHANGED</b>				
ADDRESS		CITY	STATE	ZIP
PHONE NUMBER		FAX NUMBER		

### SECTION 3: PERSON COMPLETING FORM

NAME OF ORGANIZATION YOU REPRESENT		TITLE	
STREET ADDRESS		CITY	STATE ZIP
PHONE NUMBER		EMAIL ADDRESS	

### SECTION 4: ROSTER OF PRACTITIONERS / PROVIDERS PRACTICING WITH GROUP (IF NEED MORE ROOM, ATTACH SEPARATE ROSTER SHEET)

		ACCEPTING NEW PATIENTS?			ACCEPTING NEW PATIENTS?
FULL NAME		<input type="checkbox"/> YES <input type="checkbox"/> NO	FULL NAME		<input type="checkbox"/> YES <input type="checkbox"/> NO
FULL NAME		<input type="checkbox"/> YES <input type="checkbox"/> NO	FULL NAME		<input type="checkbox"/> YES <input type="checkbox"/> NO
FULL NAME		<input type="checkbox"/> YES <input type="checkbox"/> NO	FULL NAME		<input type="checkbox"/> YES <input type="checkbox"/> NO
ARE ALL PRACTITIONERS IN GROUP STATE OF WISCONSIN MEDICAID CERTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO			IS ANYONE IN YOUR PRACTICE UNABLE TO BILL WISCONSIN MEDICAID DUE TO BEING INVESTIGATED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IN ADDITION TO ENGLISH, WHAT LANGUAGES DO YOU SPEAK IN YOUR OFFICE? <input type="checkbox"/> SPANISH <input type="checkbox"/> HMONG <input type="checkbox"/> OTHER: _____					

### SECTION 5: HOURS OF OPERATION (EXAMPLE: 8 a.m.)

MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		SUNDAY	
OPEN	CLOSE	OPEN	CLOSE	OPEN	CLOSE	OPEN	CLOSE	OPEN	CLOSE	OPEN	CLOSE	OPEN	CLOSE
REGULAR		REGULAR		REGULAR		REGULAR		REGULAR		REGULAR		REGULAR	
URGENT CARE		URGENT CARE		URGENT CARE		URGENT CARE		URGENT CARE		URGENT CARE		URGENT CARE	

### SECTION 6: FEDERAL TAX ID NUMBER (TIN) CHANGES

Changes in a tax ID number or name require you to submit a W-9 form or IRS letter (SS4 or 147C). Please attach to this form and email to: [cchp-contracting@chw.org](mailto:cchp-contracting@chw.org). (To email, file size not to exceed 4MB & types accepted: .doc; .docx; .rtf; .xls; .pdf.)

Did you attach supporting documents?  YES  NO

### SECTION 7: BEHAVIORAL HEALTH PROVIDER INFORMATION

If you're a Behavioral Health provider, please answer the following questions:

1. Do you provide home visits?  YES  NO
2. Are you able to schedule a patient visit within seven days of discharge from an inpatient facility?  YES  NO
3. Do you provide day treatment?  YES  NO

### SECTION 8: EMAIL ADDRESS CHANGE

ORGANIZATION NAME(S) ASSOCIATED WITH THIS EMAIL ADDRESS	
OLD EMAIL ADDRESS	NEW EMAIL ADDRESS

COMMENTS:

## INTERPRETER SERVICES

Chorus Community Health Plans (CCHP) complies with all applicable civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, disability, or other legally protected status, in its administration of the plan, including enrollment and benefit determinations.

- On-site interpreter services are provided to CCHP members through Language Source.
- Telephonic interpreter services are provided to CCHP members through Pacific Interpreters. Please call a Provider Relations Representative to request this service at **1-844-229-2775**
- For sign language services, call a CCHP Member Advocate at **1-877-900-2247**.

## Language Source

- Phone: (414) 607-8766
- Fax: (414) 607-8767
- Pager: (414) 201-0014
- Email: [schedule@langsource.com](mailto:schedule@langsource.com)
- TTY users, call: 711



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[chorushealthplans.org](http://chorushealthplans.org)