

## Provider/Practitioner Changes Instruction Guide



- Please reference the table below before completing any form(s)
- Attach a W9 for all changes
- With the exception of a roster, please use one form per change

*Facility/Provider = hospital, group, FQHC, RHC, etc*

*Practitioner = MD, DO, APRN, or other individual that works within a Facility/Provider location*

### EFFECTIVE DATE OF CHANGE

Changes must be received at least 30 days in advance so that the change may be made prior to a provider or practitioner seeing Oklahoma Complete Health, Ambetter of Oklahoma or Wellcare Oklahoma members.

Change Type	Required Form(s)	How to submit
<b>I have a facility name <u>and</u> TIN change</b>	Changes to a facility name <i>and</i> Tax ID (TIN) require a new Participating Provider Agreement and submission of credentialing materials.	A request for a new agreement may be made by going to: <a href="https://www.oklahomacompletehealth.com/providers/become-a-provider.html">https://www.oklahomacompletehealth.com/providers/become-a-provider.html</a> . Complete the online Contract Request Form. On the Contract Request Form, check 'new contract', complete the form in its entirety, then click on Submit
<b>I have a facility name <u>or</u> TIN change</b>	A change to the facility name <i>or</i> a change in the TIN requires a contract amendment to the Participating Provider Agreement. An updated W9 will be required.	A request for an amendment to an existing agreement may be made by going to: <a href="https://www.oklahomacompletehealth.com/providers/become-a-provider.html">https://www.oklahomacompletehealth.com/providers/become-a-provider.html</a> . Complete the online Contract Request Form. On this form, check 'amendment', complete the form in its entirety, then click on Submit.
<b>I wish to add another NPI and Service</b>	Provider Change Form Copy of License or Accreditation	Please complete the top section of the Provider Change Form Complete Section F as it relates to the new service/NPI being added. Include a copy of Licensure and/or Accreditation Submit the signed and completed form to <a href="mailto:OklahomaCompleteHealth_PR@OklahomaCompleteHealth.com">OklahomaCompleteHealth_PR@OklahomaCompleteHealth.com</a> .
<b>I wish to change the current NPI and/or Service</b>	Provider Change Form	Complete the top section of the Provider Change Form. Complete Section F as it relates to the change. Submit the signed form to <a href="mailto:OklahomaCompleteHealth_PR@OklahomaCompleteHealth.com">OklahomaCompleteHealth_PR@OklahomaCompleteHealth.com</a> .
<b>I wish to end a Service (ending a Service may be done without terming the agreement)</b>	Provider Change Form	Complete the top section of the Provider Change Form. Complete Section E and explain the reason for ending the service Submit the signed form to <a href="mailto:OklahomaCompleteHealth_PR@OklahomaCompleteHealth.com">OklahomaCompleteHealth_PR@OklahomaCompleteHealth.com</a> .
<b>Practitioner Add/Term/Change</b>	<b>Adds:</b> Roster <i>or</i> Provider Profile Sheet <b>Changes:</b> Complete Section E of the Provider Change Form <b>Terms:</b> Roster <i>or</i> complete Section E of the Provider Change Form	Please submit practitioner additions or terms on the Preferred Roster (Excel) <i>or</i> Provider Profile Sheet. Please submit completed form to <a href="mailto:OklahomaCompleteHealth_PR@OklahomaCompleteHealth.com">OklahomaCompleteHealth_PR@OklahomaCompleteHealth.com</a> .
<b>I have a Practitioner with a name change</b>	Provider Change Form <i>and</i> Legal document such as updated Medical License and/or updated DEA Certificate is required	Please complete the top section of the Provider Change Form with the Group information, then complete Section E Email both documents to <a href="mailto:OklahomaCompleteHealth_PR@OklahomaCompleteHealth.com">OklahomaCompleteHealth_PR@OklahomaCompleteHealth.com</a> .
<b>I wish to add/update an address – TIN is not changing</b>	Provider Change Form For billing address changes please also submit an updated W9	On the Provider Change Form, please complete the top section then one of the following depending on the situation: Section A – change physical address Section B – change/add second address Section C – change billing address Section D – change mailing address Email the signed form along with a W9 to <a href="mailto:OklahomaCompleteHealth_PR@OklahomaCompleteHealth.com">OklahomaCompleteHealth_PR@OklahomaCompleteHealth.com</a> .
<b>I wish to change my provider status</b>	Provider Change Form	On the Provider Change Form, please complete the top section, then complete the following: Section E – change of provider status

		Email the signed form to <a href="mailto:OklahomaCompleteHealth_PR@OklahomaCompleteHealth.com">OklahomaCompleteHealth_PR@OklahomaCompleteHealth.com</a> .
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