Network Participation Update Form
Individual Provider

Piedmont Community Health Plan values you as a network provider. Accurate provider information allows us to process claims and provide directories to members accurately. Please use this form to submit updated information at any time.

Please N/A any information which is not applicable to the requested changes.

If you have questions, please call Tammie Kovach at (434) 947-4463, ext. 226 or contact by email at Tammie.Kovach@pchp.net

Please return this form by email to: Tammie.Kovach@pchp.net or by mail:

Piedmont Community Health Plan
Attn: Tammy Kovach
2316 Atherholt Rd.
Lynchburg, VA 24501

Date Update Information Completed:

I. PRACTITIONER INFORMATION

A. General Information

First Name:		MI:		Last Name:		Suffix:		Degree(s):	
Gender:		DOB:		SSN:					

B. Professional Registration

NPI (for provider):		License:	
CAQH #:		DEA#:	
TIN:		Note: An Updated W-9 is required with any update to a TIN.	
Malpractice Insurance Company:			
Claim Amount:			
Aggregate Amount:			

C. Practitioner Details

Primary Specialty:		
Medicare Specialty *(used for publication of provider in the Medicare Provider Directory. Choose from the list provided)*		
	Code: *(will autopopulate)*	
Board Certified?	Name of Certifying Board:	
○ Yes ○ No		
Subspecialty:		
Board Certified?	Name of Certifying Board:	
○ Yes ○ No		
Additional Special Skills or Training:		

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II. AFFILIATION & PRIVILEGES INFORMATION

1.	Facility Name:	
	Address:	
	Phone Number:	
2.	Facility Name:	
	Address:	
	Phone Number:	
3.	Facility Name:	
	Address:	
	Phone Number:	

III. GROUP INFORMATION

Please complete this section even if you are requesting the addition of a provider to an existing group.
If applying as a solo provider, this information should be applicable to the solo practice.

A. General Information

Previous Legal Group/Practice Name:	
New Legal Group/Practice Name:	

The name of the practice as it is registered with legal entities for billing, W-9, NPI, etc.

B. Contact and Address Information

Practice Manager Name:		Title:	

This person may be contacted by us to update or confirm practice information.

Phone:		Email:	
Fax:		Other Contact Info:	

Mode of Contact Preference: ☐ Phone ☐ Email ☐ Fax

Previous Billing Address

Address Line 1:					
Address Line 2:					
City:		State:		Zip:	

New Billing Address

Address Line 1:					
Address Line 2:					
City:		State:		Zip:	

Previous Mailing Address

Address Line 1:					
Address Line 2:					
City:		State:		Zip:	

New Mailing Address

Address Line 1:					
Address Line 2:					
City:		State:		Zip:	

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IV. FACILITY DETAILS

This information pertains to the locations where the provider accepts appointments. It will be used for the practice listing in the provider directories. Please copy this page as needed if you schedule patients in more than two locations.

LOCATION 1 – PRIMARY LOCATION

Common Group/Practice Location Name:	

The name of the practice as it is referred to when staff answer phones. This will be listed in the Medicare Provider Directory. CMS/Medicare may audit the accuracy of this information by calling the practice and reconciling the greeting with the name in the directory.

Location NPI:	

Physical Address

Address Line 1:						Phone:	
Address Line 2:						Fax:	
City:		State:		Zip:		Email:	
Tax ID:						TTY:	

County or City of Physical Location:	

Availability

Will only see patients within an age range (Accepted age range: to)

Check which days of the week the provider is regularly available for accepting appointments. If the days of the week the provider is available for appointments is not on a regular schedule, choose "varies".

☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun ☐ Varies

Select all that currently apply to this individual provider at this location:

☐ Accepts Medicaid
☐ Accepting New Patients
☐ Accepts Medicare
☐ Accepting New Medicare Advantage Patients

Languages

Please list all languages other than English that are spoken by provider, clinical staff, and non-clinical staff in the group or practice.

Language	Spoken by (check all that apply)		
	☐ Provider	☐ Clinical Staff	☐ Non-Clinical Staff
	☐ Provider	☐ Clinical Staff	☐ Non-Clinical Staff
	☐ Provider	☐ Clinical Staff	☐ Non-Clinical Staff

Handicap Access

Please list any provisions made in the practice location that allow access for patients with physical disabilities. This information will be used to advise our members.

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LOCATION 2 – SECONDARY LOCATION							
Common Group/Practice Location Name:							
The name of the practice as it is referred to when staff answer phones. This will be listed in the Medicare Provider Directory. CMS/Medicare may audit the accuracy of this information by calling the practice and reconciling the greeting with the name in the directory.							
Location NPI:							
Physical Address							
Address Line 1:					Phone:		
Address Line 2:					Fax:		
City:		State:		Zip:	Email:		
Tax ID:					TTY:		
County or City of Physical Location:							

Availability

Will only see patients within an age range (Accepted age range:)

Check which days of the week the provider is regularly available for accepting appointments. If the days of the week the provider is available for appointments is not on a regular schedule, choose "varies".

☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun ☐ Varies

Select all that currently apply to this individual provider at this location:

☐ Accepts Medicaid
☐ Accepting New Patients
☐ Accepts Medicare
☐ Accepting New Medicare Advantage Patients

Languages

Please list all languages other than English that are spoken by provider, clinical staff, and non-clinical staff in the group or practice other than English.

Language	Spoken by (check all that apply)		
	☐ Provider	☐ Clinical Staff	☐ Non-Clinical Staff
	☐ Provider	☐ Clinical Staff	☐ Non-Clinical Staff
	☐ Provider	☐ Clinical Staff	☐ Non-Clinical Staff

Handicap Access

Please list any provisions made in the practice location that allow access for patients with physical disabilities. This information will be used to advise our members.

Check here to Request to Leave PCHP's Network: ☐
Reason for leaving network:

Completed by (Name):_____

Please return this form by email to: Tammie.Kovach@pchp.net or by mail:
Piedmont Community Health Plan
Attn: Tammie Kovach
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Lynchburg, VA 24501