PROVIDER MAINTENANCE REQUEST FORM

PROVIDER INFORMATION

PROVIDER NAME: _____

NPI: _____ DATE OF SUBMISSION: _____

EFFECTIVE DATE OF CHANGES:			
Maintenance Request (Check all that apply):			
☐	ADDRESS (Adding/terming a location or relocation)	☐	TIN CHANGE
☐	PROVIDER CHANGE (Adding or terming a provider)	☐	PHONE, FAX, OR OFFICE HOURS
☐	AFFILIATION CHANGE (Adding/terming an affiliation)	☐	CHANGE TO NON-PARTICIPATING PROVIDER (No Member Assignment)

Maintenance Request Applies to the following:	
Provider Type	☐ PCP ☐ OB/GYN ☐ Mid-Levels ☐ Specialist:

PLEASE SEE THE BELOW CHECKLISTS AND INCLUDE REQUIRED DOCUMENTATION FOR EACH APPLICABLE MAINTENANCE REQUEST.

PCPs, OB/GYN, & Mid-Levels, Specialists:

- **For W-9 changes, an updated W-9 form is required.**
- **For any IPA Changes, please attach new contract signature page and updated W-9 form.**

Location(s) to be added and/or relocating to address:

Location(s) to be termed:

New Phone: _____

New Fax: _____

New Hours: _____

Affiliation Change(s):

Changing to Non-Participating Provider:

Provider(s) to be TERMED: _____ Effective Date: _____

_____ Effective Date: _____

_____ Effective Date: _____

Provider(s) to be ADDED: _____ Effective Date: _____

_____ Effective Date: _____

_____ Effective Date: _____

Comments:

By signing below, I, *(Insert Provider Name)* _____ authorize IEHP to make said changes as noted on maintenance form:

Signature: _____ Date: _____

Please fax this form to (909) 890-2968 upon completion.