MINNESOTA UNIFORM PRACTITIONER CHANGE FORM

Add – Remove – Change Demographic Data for Credentialed Practitioners and Specialists. Not Subject to Credentialing: ER Physician, Hospitalist Pathologist, Radiologist, Anesthesiologist, CRNA, Neonatologist, Dietitian, Therapists (PT; OT; SLP), Audiologist – *check with entity if unsure.*
If "NO", practitioner will not be included in the directory.

Demographic Verification and Authorization

Completed and authorized on behalf of the practitioner by:

Name/Title: _____   Date: _____

Organization Name: _____

Phone #: _____   FAX #: _____   E-Mail: _____

Practitioner Demographic Information for this Request

Enter name as shown on state healthcare license

Last: _____   First: _____   MI: _____   SSN: _____

Title: ☐ MD   ☐ DO   ☐ MBBS   ☐ DC   ☐ DPM   ☐ DDS   ☐ Other (Please Specify):_____

DOB: _____   Gender: ☐ M - Male   ☐ F - Female   ☐ X - Unspecified or Another Gender Identity   ☐ U - Undisclosed

DEA: _____   State: _____   Type I NPI: _____   License Number: _____   State: _____

Languages spoken fluently to treat patients: _____

Race and/or ethnicity: The following information is optional and may be used in provider directories to help members make informed choices and/or to help ensure that our network of providers is adequate to meet the needs of our members.

Check here if you do not wish for your race and/or ethnicity to be displayed in provider directories: ☐

Select one or more categories:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Prefer not to say
- ☐ Other (please specify):_____

ADD/REMOVE Practitioner

Practicing as (select all applicable): ☐ Primary Care   ☐ Specialist   ☐ Urgent Care   ☐ Locum Tenens   ☐ Hospitalist/Hospital-Based
☐ Moonlighting Resident   ☐ Other: _____   *Services provided via (select all applicable):* ☐ Telehealth   ☐ In-Person

☐ Clinic   ☐ Hospital   Clinic/Hospital Name: _____

Address:		City/State:		Zip:

Tax ID:	Type 2 Site NPI:	Directory Suppress: YES ☐ NO ☐	Regularly Sees Patients Here at Least Once Per Week: YES ☐ *NO ☐	Accepting New Patients: YES☐ NO ☐

Effective Date:	Practicing Specialty at this Site:	Primary Site: ☐ YES ☐ NO

☐ **ADD**	☐ **REMOVE**	Remove ALL sites for this TIN: **YES** ☐ **NO** ☐	**Remove Reason:**

Practicing as (select all applicable): ☐ Primary Care   ☐ Specialist   ☐ Urgent Care   ☐ Locum Tenens   ☐ Hospitalist/Hospital-Based
☐ Moonlighting Resident   ☐ Other: _____   *Services provided via (select all applicable):* ☐ Telehealth   ☐ In-Person

☐ Clinic   ☐ Hospital   Clinic/Hospital Name: _____

Address:		City/State:		Zip:

Tax ID:	Type 2 Site NPI:	Directory Suppress: YES ☐ NO ☐	Regularly Sees Patients Here at Least Once Per Week: YES ☐ *NO ☐	Accepting New Patients: YES☐ NO ☐

Effective Date:	Practicing Specialty at this Site:	Primary Site: ☐ YES ☐ NO

☐ **ADD**	☐ **REMOVE**	Remove ALL sites for this TIN: **YES** ☐ **NO** ☐	**Remove Reason:**

CHANGE Practitioner Demographic Data

Effective Date of Change:

Old:	**New:**
Last Name: _____	Last Name: _____
First Name: _____ MI:_____	First Name: _____ MI:_____
Specialty: _____	Specialty: _____
License #: _____ State: _____	License #: _____ State: _____
DEA #: _____	DEA #: _____

List additional practice locations to ADD/REMOVE on the Site Location Addendum and attach to this form.

☐ **Check here if you have additional Site Location Addendum forms attached.**

SITE LOCATION ADDENDUM
(Please make as many extra copies as necessary)

ADDITIONAL LOCATION(s) FOR:

Last: _____ First: _____ MI: _____ NPI: _____

ADD/REMOVE Practitioner

Practicing as (select all applicable): ☐ Primary Care ☐ Specialist ☐ Urgent Care ☐ Locum Tenens ☐ Hospitalist/Hospital-Based
☐ Moonlighting Resident ☐ Other: _____ *Services provided via (select all applicable):* ☐ Telehealth ☐ In-Person

☐ Clinic ☐ Hospital Clinic/Hospital Name:

Address:		City/State:	Zip:

Tax ID:	Type 2 Site NPI:	Directory Suppress: YES ☐ NO ☐	Regularly Sees Patients Here at Least Once Per Week: YES ☐ *NO ☐	Accepting New Patients: YES ☐ NO ☐

Effective Date:	Practicing Specialty at this Site:	Primary Site: ☐ YES ☐ NO

☐ **ADD** ☐ **REMOVE** Remove ALL sites for this TIN: **YES ☐ NO ☐**   **Remove Reason:**

ADD/Remove Practitioner

Practicing as (select all applicable): ☐ Primary Care ☐ Specialist ☐ Urgent Care ☐ Locum Tenens ☐ Hospitalist/Hospital-Based
☐ Moonlighting Resident ☐ Other: _____ *Services provided via (select all applicable):* ☐ Telehealth ☐ In-Person

☐ Clinic ☐ Hospital Clinic/Hospital Name:

Address:		City/State:	Zip:

Tax ID:	Type 2 Site NPI:	Directory Suppress: YES ☐ NO ☐	Regularly Sees Patients Here at Least Once Per Week: YES ☐ *NO ☐	Accepting New Patients: YES ☐ NO ☐

Effective Date:	Practicing Specialty at this Site:	Primary Site: ☐ YES ☐ NO

☐ **ADD** ☐ **REMOVE** Remove ALL sites for this TIN: **YES ☐ NO ☐**   **Remove Reason:**

ADD/REMOVE Practitioner

Practicing as (select all applicable): ☐ Primary Care ☐ Specialist ☐ Urgent Care ☐ Locum Tenens ☐ Hospitalist/Hospital-Based
☐ Moonlighting Resident ☐ Other: _____ *Services provided via (select all applicable):* ☐ Telehealth ☐ In-Person

☐ Clinic ☐ Hospital Clinic/Hospital Name:

Address:		City/State:	Zip:

Tax ID:	Type 2 Site NPI:	Directory Suppress: YES ☐ NO ☐	Regularly Sees Patients Here at Least Once Per Week: YES ☐ *NO ☐	Accepting New Patients: YES ☐ NO ☐

Effective Date:	Practicing Specialty at this Site:	Primary Site: ☐ YES ☐ NO

☐ **ADD** ☐ **REMOVE** Remove ALL sites for this TIN: **YES ☐ NO ☐**   **Remove Reason:**

ADD/REMOVE Practitioner

Practicing as (select all applicable): ☐ Primary Care ☐ Specialist ☐ Urgent Care ☐ Locum Tenens ☐ Hospitalist/Hospital-Base
☐ Moonlighting Resident ☐ Other: _____ *Services provided via (select all applicable):* ☐ Telehealth ☐ In-Person

☐ Clinic ☐ Hospital Clinic/Hospital Name:

Address:		City/State:	Zip:

Tax ID:	Type 2 Site NPI:	Directory Suppress: YES ☐ NO ☐	Regularly Sees Patients Here at Least Once Per Week: YES ☐ *NO ☐	Accepting New Patients: YES ☐ NO ☐

Effective Date:	Practicing Specialty at this Site:	Primary Site: ☐ YES ☐ NO

☐ **ADD** ☐ **REMOVE** Remove ALL sites for this TIN: **YES ☐ NO ☐**   **Remove Reason:**