Medical Provider Change Form

Keystone First
Keystone First Community HealthChoices
Keystone First VIP Choice

Keystone First
Family of Health Plans

Current practice information			
☐ Group practice name: ☐ Individual name:			
☐ Group practice ID: ☐ Individual ID:	Keystone First ID:	NPI:	PPID:
Contact person name (please print clearly):			Phone:
Email:			Fax:
Authorizing signature (physician/office manager) (Change will not be completed without a signature.)		Today's date:	Effective date of change:

Provider change information			
Please provide complete information. This request will be processed for Keystone First, Keystone First Community HealthChoices, and Keystone First VIP Choice. If any of these changes result in a change on your W-9, you must submit a copy of your W-9 with this change form. **Please note:** Practitioners must complete our credentialing process before they will be added to your practice as a participating provider. Refer to our websites for credentialing requirements: **www.keystonefirstpa.com**, **www.keystonefirstchc.com**, **www.keystonefirstvipchoice.com.**			
Type of change: Please check all that apply.	☐ Adding a practice ☐ Joining a practice ☐ Phone number change	☐ Adding an office location ☐ Changing an office location ☐ Other (attach documentation)	☐ Fax number change ☐ Name change only

Previous office information			New office information		
Keystone First group provider ID:	NPI:		Keystone First group provider ID:	NPI:	
Name:			Name:		
Street address:			Street address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:	Fax:	Office hours:	Phone:	Fax:	Office hours:
☐ Close this location					

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Add practitioners (New practitioners must complete our Credentialing process before they are added as a participating provider.)				
1. (Last name, first name, middle initial)	Degree:	NPI:	PPID:	
PPID location extension:	Street address:			
City:			State:	Zip:
PPID location extension:	Street address:			
City:			State:	Zip:
2. (Last name, first name, middle initial)	Degree:	NPI:	PPID:	
PPID location extension:	Street address:			
City:			State:	Zip:
PPID location extension:	Street address:			
City:			State:	Zip:
3. (Last name, first name, middle initial)	Degree:	NPI:	PPID:	
PPID location extension:	Street address:			
City:			State:	Zip:
PPID location extension:	Street address:			
City:			State:	Zip:

Terminate practitioners (Please give us 60 days' advance notice when a practitioner is leaving the group.)				
1. (Last name, first name, middle initial)	Degree:	NPI:	PPID:	
PPID location extension:	Street address:			
City:			State:	Zip:
PPID location extension:	Street address:			
City:			State:	Zip:
2. (Last name, first name, middle initial)	Degree:	NPI:	PPID:	
PPID location extension:	Street address:			
City:			State:	Zip:
PPID location extension:	Street address:			
City:			State:	Zip:
3. (Last name, first name, middle initial)	Degree:	NPI:	PPID:	
PPID location extension:	Street address:			
City:			State:	Zip:
PPID location extension:	Street address:			
City:			State:	Zip:
For additional changes/locations, please attach a separate sheet.				

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Billing location change				
Street address 1:			Phone:	Fax:
Street address 2:			Email:	
City:	State:	Zip:	Federal Tax ID (change in federal ID requires new W-9):	

Change of ownership
Legal business name of new owner:
Federal Tax ID (requires new W-9):
Effective date of ownership:

Notes/comments

Please mail or fax this change form and supporting documents to:

Keystone First
Provider Network Management
200 Stevens Drive
Philadelphia, PA 19113
Fax: 1-215-937-5343