Provider Information Form

Use this form to register and/or update your provider information (e.g., service location(s), payment address, tax identification number, etc.) with Gold Coast Health Plan. Please complete all sections as applicable. Providing complete and legible information will expedite your request and help ensure accurate processing. The completed form should be returned by email to providerrelations@goldchp.org

Section 1: Provider Information

Provider's First Name	Last Name	Title	Degree
Group Association Name			Effective Date of Request (MM/DD/YY)
Date of Birth	Individual NPI		Corporate NPI
CAQH Provider ID (Physicians only)	Medical License Number		Tax ID or SSN
**Primary Specialty Type	Secondary Specialty Type		☐ PCP ☐ Specialist *Only chose one
Patient Age Limits From To	Patient Gender Limits ☐Male ☐Female ☐Both		**PCP Only**: *Total Capacity (50-2000) *Must chose a minimum of 50 /maximum of 2000
Office Contact Name	Telephone Number (for appointments) ( ) -		Email Address

*Legal documentation (e.g., marriage license) is required for changes to last name
**Only Primary Specialty will be listed in provider directory

Section 2: Languages Spoken

List non-English languages spoken by provider and/or staff in order of fluency. Check 'P' for Provider and 'S' for Staff.

(1) ______ P ☐ S ☐ (2) ______ P ☐ S ☐ (3) _____ P ☐ S ☐

Section 3: Accepting New Patients

☐ Yes ☐ No ☐ Existing Patients Only

Section 4: Service Location

Please complete a separate form for each additional location, or, attach a company roster which includes the requested information below.

☐ Add new ☐ Termination ☐ Relocated ☐ Change to existing location

Current location			**Previous Location (Changes only)**		
Location Name (If different than Group Association Name above)			Location Name (If different than Group Association Name above)		
Street Address			Street Address		
City	State	Zip	City	State	Zip
Telephone Number ( ) -	Fax Number ( ) -		Telephone Number ( ) -	Fax Number ( ) -	
Email Address			Email Address		
Location NPI (if different than Corporate NPI)			Location NPI (if different than Corporate NPI)		

Section 5: Office Hours

Office Hours							
	Mon	Tue	Wed	Thu	Fri	Sat	Sun
A.M.							
P.M.							

Section 6: Authorization Mailing Address ☐ Check box if same as service location

Current Location			**Previous (Changes only)**		
Provider Name (last, first, middle initial/business name)			Provider Name (last, first, middle initial/business name)		
Street Address			Street Address		
City	State	Zip	City	State	Zip
Telephone Number ( ) -	Fax Number ( ) -		Telephone Number ( ) -	Fax Number ( ) -	
Email Address			Email Address		

Section 7: Payment/Billing Address ☐ Check box if same as service location

A signature at the bottom of this form by the Tax ID owner is required for all payment address changes.

Current Location			**Previous (Changes only)**		
Provider Name (last, first, middle initial/business name)			Provider Name (last, first, middle initial/business name)		
Street Address			Street Address		
City	State	Zip	City	State	Zip
Telephone Number ( ) -	Fax Number ( ) -		Telephone Number ( ) -	Fax Number ( ) -	
Email Address			Email Address		

Section 8: Tax Identification/Employer Identification Number (TIN/EIN)

If joining a participating group, please use the group's TIN to associate the request with the participating group.
In order to update your Tax ID, a **completed W-9** must be attached to this form.

Previous TIN/EIN	New TIN/EIN	Effective Date of Change

Section 9: Hospital Affiliation Update

A **hospital privilege letter** from the facility along with written notification from the provider's office (administrator, manager, provider, etc.) and/or **attestation form** for hospital-based physicians is required.

Hospital Name	Hospital Provider Number	Hospital NPI	Add/Delete?	Effective/ Expiration Date
(1)			Add ☐ Delete ☐	
(2)			Add ☐ Delete ☐	

** If no hospital privileges please provide a letter or copy of an agreement with provider that will admit for you.

NOTE: A signed ***Payment Authorization Form (PA)*** must be completed when (1) adding a provider (2) a provider joins a group.

Additional Comments

Print Name of Physician/Provider_____ ___________

Signature of Physician/Provider _______________________________

Date _____