



NETWORK PROVIDER FACILITY CREDENTIALING INFORMATION

Update Forms, Change Forms and Add Location Forms

Change of Address

- Send the old address with the new address. The old address information must be removed from our system when updating provider information with a new address.
- All three addresses, service, mailing and billing, must be provided for the new location.

Change of Tax ID Number

- A completed and signed W-9 form must accompany all tax ID number changes. The old tax ID number should be supplied to terminate the old number and activate the new identification number.

Address Classifications

- **Service Address**-This address is used for the physical location of the provider and/or the location where health care services are performed. The service address will be used for the on-line provider directory which is used by members and providers to identify and locate all HealthChoice Network Providers
- **Mailing Address**-This address is used for all correspondence and credentialing information.
- **Billing Address**-This address is used for submitting all claims to HealthChoice for processing and appears in box 33 of the CMS-1500 claim form or box 1/2 on the UB-04 claim form. Claims will be paid exclusively to the billing address. Please also include the name which claims will be submitted under.

Insurance Certificate or Face Sheet

Insurance Certificate must specifically indicate that the applicant is the insured, insurance limits must be at the level required by the contract and must clearly state that it is for professional/general liability coverage. Product liability insurance is acceptable for DME only.

It is vital that you notify HealthChoice Provider Relations immediately regarding any changes to the service, mailing or billing addresses to prevent delays in receiving notifications regarding the plan's schedule of benefits, the fee schedule and the issuance of claim payments.

Claim and eligibility information is available through the new HealthChoice Provider Web Site at www.sib.ok.gov/providers. Click on "Claim Link" on the left column to go to the EDS web site. Register for user ID and password. Information regarding claim edits is also available at this site.

Network Facility Change Form

Company Name: _____

Classification: _____ NPI# _____

New Physical Address

(List any additional physical addresses on a separate sheet)

Phone: () _____

Fax: () _____

Contact Person: _____

Email Address: _____

New Mailing Address

(List any additional mailing locations on a separate sheet)

Phone: () _____

Fax: () _____

Contact Person: _____

Email Address: _____

New Billing Address

(List any additional billing addresses on a separate sheet)

Phone: () _____

Fax: () _____

Contact Person: _____

Email Address: _____

Tax ID Number (TIN)

(Attach W9 if new TIN)

Tax ID Number: _____

Did this TIN change with new address? Yes No

If Yes, previous TIN: _____

Effective date of this new address: _____

Is this an additional location? Yes No

If No, list the old address below:

Old Physical Address

Phone: () _____

Date this address terminated: _____

Contact Name: (please print) _____

Authorized Signature: _____

Old Billing Address

Phone: () _____

Phone: () _____

Date: _____

FAILURE TO PROVIDE THE REQUESTED INFORMATION COULD RESULT IN A DELAY OF PAYMENT AND/OR REIMBURSEMENT BEING MADE AT AN "OUT-OF-NETWORK" RATE