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 D	Other (Please	Specify):								
DOB: Gender: DM-Male F-Female										
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										
categories: Black or African American Native Hawaiian or	Other Pacific Isla	ander Other (please specify):								
ADD/REMOVE Practitioner	Ularant Co	The same Tenene	Li 't-1'-t'l Issnital Bood							
Practicing as (select all applicable): ☐ Primary Care ☐ Specialist ☐ Moonlighting Resident ☐ Other: Set	☐ Urgent Ca ervices provided	are □ Locum Tenens □ I via (select all applicable): □ Te	Hospitalist/Hospital-Based lehealth ☐ In-Person							
☐ Clinic ☐ Hospital Clinic/Hospital Name:										
Address: C	ity/State:		Zip:							
Tax ID: Type 2 Site NPI: Directory Suppress: YES □ NO □	Regulari	ly Sees Patients Here at Least Once Per V	Neek: 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:								
	=		Hospitalist/Hospital-Based							
☐ Moonlighting Resident ☐ Other: Services provided via (select all applicable): ☐ Telehealth ☐ In-Person										
☐ Clinic ☐ Hospital Clinic/Hospital Name:										
	ity/State:	Company of Land Once Dec	Zip:							
Tax ID: Type 2 Site NPI: Directory Suppress: YES □ NO □	Regulari	ly Sees Patients Here at Least Once Per \ YES \(\Boxed{\text{YES}} \) *NO \(\Boxed{\text{T}}	Week: Accepting New Patients: YES□ NO□							
Effective Date: Practicing Specialty at this Site:	1	Primary Site: YES NO								
ADD REMOVE Remove ALL sites for this TIN: YES	П оо П	Remove Reason:								
CHANGE Practitioner Demographic Data		<u></u>								
Effective Date of Change:										
Old: New:										
Last Name:	Last Name:									
First Name: MI:		MI:								
Specialty:	Specialty:									
License #: State: DEA #:	License #:	License #: State: DEA #:								
		tion Addondrin and attac	la ta thia farma							
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										

THE FOLLOWING SITE LOCATION ADDENDUM FORM IS USED IN CONJUNCTION WITH THE MINNESOTA UNIFORM PRACTITIONER CHANGE FORM WHEN ADDING OR REMOVING PRACTITIONERS FROM MORE THAN TWO SITES. THIS FORM WILL ONLY BE ACCEPTED WHEN IT IS ACCOMPANIED BY A COMPLETED MINNESOTA UNIFORM PRACTITIONER CHANGE FORM.

SITE LOCATION ADDENDUM

(Please make as many extra copies as necessary)

ADDITIONAL LOCATION(s) FOR:

Last:				First:		N	/II: NPI: _		
ADD/REI	IOVE Pr	actitio	ner						
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:	dress:			City/State	City/State:		Zip:		
Tax ID:		Type 2	2 Site NPI:	Directory Suppress: YES □ NO □	,	Regula	arly Sees Patients Here at Least Once P YES *NO *NO	er Week:	Accepting New Patients: YES□ NO□
Effective Date	e:		Practicing Spe	cialty at this Site:			<u> </u>		
			, racioning operating artiful cities				Primary Site:	☐ YES	S NO
☐ ADD		MOVE		ites for this TIN: YES	□ NO□		Remove Reason:		
ADD/Remo	ove Prac	titione	er						
			<i>cable):</i> □ Prima	ry Care Speciali	st 🗌 Urg	ent Ca	are	Hospita	alist/Hospital-Based
☐ Moonlight	ting Resid	dent	Other:		Services pr	ovided	via (select all applicable): Te	elehealth	n 🗌 In-Person
☐ Clinic ☐] Hospita	al Clini	c/Hospital Name:						
Address:		Ci		City/State:			Zip:		
Tax ID:		Type 2	2 Site NPI:	Directory Suppress: YES □ NO □]	Regula	arly Sees Patients Here at Least Once P YES *NO *NO	er Week:	Accepting New Patients: YES NO
Effective Date	ffective Date: Practicing Specialty at this Site: Primary Site: ☐ YES ☐ NO					□NO			
□ADD	REM	IOVE	Remove ALL site	es 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:									
	•		<u> </u>		City/State:			Zini	
Address: Tax ID:		Tuno 1	O Cito NIDI:	Dinastani Cimanasa	City/State:	Dogula	arky Saca Dationta Haro at Lagat Once D	Zip:	Accepting New Patients:
		Type 2	2 Site NPI:	Directory Suppress: YES □ NO □]	Regula	arly Sees Patients Here at Least Once P YES *NO *NO	er vveek.	YES NO
Effective Date	Effective Date: Practicing Specialty at this Site:					Primary Site:	☐ YES	□ NO	
☐ ADD	REM	IOVE	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	2 Site NPI:	Directory Suppress: YES □ NO □	<u> </u>	Regula	arly Sees Patients Here at Least Once P	er Week:	Accepting New Patients:
Effective Date: Practicing Specialty at this Site: Primary Site: YES NO									
□ADD	REM	MOVE	Remove ALL sites for this TIN: YES NO Remove Reason:						