Provider Information Change (PIC) Form

Form is to be completed for existing providers/practitioners only
Send completed form to: contracting@procareadvantageplan.com

PIC Form Submitted by: _____ PIC Form Approved By: _____
Date of Submission: _____ Approval Date: _____

Type of Change: (Check Appropriate Box)

☐ Billing Address Update ☐ Payment Address Update ☐ Physical/Practice Update

☐ Change of Address/Phone/Fax# ☐ Add Address (New Location) ☐ Provider Termination (Requires leadership review)

☐ Remove/Terminate Address ☐ Contract/Group Termination ☐ Name Change/Change of Ownership

☐ Panel Status Change

Identifying Information:

Group Legal Business Name: As reported to the IRS:
_____

Effective Date of Change (cannot be retroactive):
_____

Group Legal 'Doing Business As' (if applicable):
_____

Group Tax ID Number:
_____

Group NPI Number:
_____

Provider/Practitioner Name:
_____

Provider/Practitioner NPI:
_____

Address/Phone/Fax Change:

Change From/Remove Address Type:	☐ Primary	☐ Additional and/or Billing	***Change To/Add Address Type:***	☐ Primary	☐ Additional and/or billing
Street (Add P.O. Box Number if applicable for Billing Address):			Street (Add P.O. Box Number if applicable for Billing Address):		
City:			City:		
State:			State:		
Zip:			Zip:		
County:			County:		
Phone:			Phone:		
Fax:			Fax:		

Provider Termination:

☐ No longer with group (practitioner)	☐ Deceased	☐ Retiring	☐ Other

Comments/Special Instructions:

PIC Form Created: Sept 2023