



# Provider Status Change Form

(Please note that blanks in any area may cause delay in processing your request; answer what is applicable to your reason for request)

Name of Provider(s):
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<b>Select the reason for this request</b>		
<input type="checkbox"/> Provider Termination(select reason to right)	<input type="checkbox"/> Retirement	<input type="checkbox"/> Expired
	<input type="checkbox"/> Leave of Absence	<input type="checkbox"/> Moved out of Area
Date Effective:	<input type="checkbox"/> Resignation	<input type="checkbox"/> Unknown

<input type="checkbox"/> Additional Practice Location	<input type="checkbox"/> Change of Provider Affiliation	Date Effective:
<input type="checkbox"/> Practice Location Change	<input type="checkbox"/> Other(please explain):	

<b>Current Panel Information</b> (complete in full)	<input checked="" type="checkbox"/> if change to this information	<b>New Information</b> (if different than current)
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Tax ID:	<input type="checkbox"/>	
Office Name:	<input type="checkbox"/>	
Street Address:	<input type="checkbox"/>	
Suite #:	<input type="checkbox"/>	
City:	<input type="checkbox"/>	
State:	<input type="checkbox"/>	
County:	<input type="checkbox"/>	
Zip:	<input type="checkbox"/>	
Telephone No.:	<input type="checkbox"/>	
Fax No.:	<input type="checkbox"/>	
Individual NPI Number:	<input type="checkbox"/>	
NPI group # (if applicable)	<input type="checkbox"/>	
Location to be listed in the directory? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Location to be listed in the directory? <input type="checkbox"/> Yes <input type="checkbox"/> No
Accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospital Privileges Held at:	<input type="checkbox"/>	
Location Handicap Accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/> Practice Closed	Date Effective:
<input type="checkbox"/> All locations <input type="checkbox"/> Specific Locations(please list)	

Name of Contact Person :	Phone No.:
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Email Address:
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<b>Correspondence address for mailing purposes:</b>
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Street Address:	Suite #:	City:	State:	Zip:
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<b>Billing address for remit purposes:</b>
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Street Address:	Suite #:	City:	State:	Zip:
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Please fax this completed form to the AultCare Credentialing Department at 330-363-6421, e-mail [credentialing@aultcare.com](mailto:credentialing@aultcare.com), or mail to:  
 AultCare Credentialing Department  
 PO Box 6910  
 Canton, OH 44706

Please contact AultCare Credentialing at **330-363-1400** if you have any questions Monday-Friday 8:00 am to 4:30 pm.