

MINNESOTA UNIFORM PRACTITIONER CHANGE FORM – Revised December 2017

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*

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

****As shown on your state License****

Last: _____ First: _____ MI: _____ SSN: _____

Title: MD DO MBBS Other _____ DOB: _____
 DC DPM DDS _____ Female Male

DEA: _____ State: _____ Type I NPI: _____ License Number: _____ State: _____

Languages spoken fluently to treat patients: _____

ADD/REMOVE Practitioner

Practicing as: Primary Care Specialist Urgent Care Locum Tenens Moonlighting Resident Hospitalist
 Hospital Based only Teaching/Research only Other (specify) _____

Clinic Hospital Clinic/Hospital Name: _____

Address: _____ City/State: _____ Zip: _____

Tax ID: _____ Type 2 NPI for this site: _____ Directory Suppress? YES NO 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: _____

ADD/REMOVE Practitioner

Practicing as: Primary Care Specialist Urgent Care Locum Tenens Moonlighting Resident Hospitalist
 Hospital Based only Teaching/Research only Other (specify) _____

Clinic Hospital Clinic/Hospital Name: _____

Address: _____ City/State: _____ Zip: _____

Tax ID: _____ Type 2 NPI for this site: _____ Directory Suppress? YES NO 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: _____

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.

CHANGE Practitioner Demographic Data

Effective Date of Change:

Old:		New:	
Last Name: _____	MI: _____	Last Name: _____	MI: _____
First Name: _____	MI: _____	First Name: _____	MI: _____
Specialty: _____		Specialty: _____	
License #: _____	State: _____	License #: _____	State: _____
DEA #: _____		DEA #: _____	

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: _____ MI: _____ NPI: _____

ADD/REMOVE Practitioner					
Practicing as: <input type="checkbox"/> Primary Care <input type="checkbox"/> Specialist <input type="checkbox"/> Urgent Care <input type="checkbox"/> Locum Tenens <input type="checkbox"/> Moonlighting Resident <input type="checkbox"/> Hospitalist <input type="checkbox"/> Hospital Based only <input type="checkbox"/> Teaching/Research only <input type="checkbox"/> Other (specify) _____					
<input type="checkbox"/> Clinic <input type="checkbox"/> Hospital Clinic/Hospital Name: _____					
Address: _____			City/State: _____		Zip: _____
Tax ID: _____		Type 2 NPI for this site: _____		Directory Suppress? <input type="checkbox"/> YES <input type="checkbox"/> NO Accepting new patients? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Effective Date: _____		Practicing Specialty at this Site: _____		Primary Site? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> ADD	<input type="checkbox"/> REMOVE	Remove ALL sites for this TIN? YES <input type="checkbox"/> NO <input type="checkbox"/>		Remove Reason: _____	

ADD/REMOVE Practitioner					
Practicing as: <input type="checkbox"/> Primary Care <input type="checkbox"/> Specialist <input type="checkbox"/> Urgent Care <input type="checkbox"/> Locum Tenens <input type="checkbox"/> Moonlighting Resident <input type="checkbox"/> Hospitalist <input type="checkbox"/> Hospital Based only <input type="checkbox"/> Teaching/Research only <input type="checkbox"/> Other (specify) _____					
<input type="checkbox"/> Clinic <input type="checkbox"/> Hospital Clinic/Hospital Name: _____					
Address: _____			City/State: _____		Zip: _____
Tax ID: _____		Type 2 NPI for this site: _____		Directory Suppress? <input type="checkbox"/> YES <input type="checkbox"/> NO Accepting new patients? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Effective Date: _____		Practicing Specialty at this Site: _____		Primary Site? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> ADD	<input type="checkbox"/> REMOVE	Remove ALL sites for this TIN? YES <input type="checkbox"/> NO <input type="checkbox"/>		Remove Reason: _____	

ADD/REMOVE Practitioner					
Practicing as: <input type="checkbox"/> Primary Care <input type="checkbox"/> Specialist <input type="checkbox"/> Urgent Care <input type="checkbox"/> Locum Tenens <input type="checkbox"/> Moonlighting Resident <input type="checkbox"/> Hospitalist <input type="checkbox"/> Hospital Based only <input type="checkbox"/> Teaching/Research only <input type="checkbox"/> Other (specify) _____					
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Address: _____			City/State: _____		Zip: _____
Tax ID: _____		Type 2 NPI for this site: _____		Directory Suppress? <input type="checkbox"/> YES <input type="checkbox"/> NO Accepting new patients? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Effective Date: _____		Practicing Specialty at this Site: _____		Primary Site? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> ADD	<input type="checkbox"/> REMOVE	Remove ALL sites for this TIN? YES <input type="checkbox"/> NO <input type="checkbox"/>		Remove Reason: _____	

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<input type="checkbox"/> Clinic <input type="checkbox"/> Hospital Clinic/Hospital Name: _____					
Address: _____			City/State: _____		Zip: _____
Tax ID: _____		Type 2 NPI for this site: _____		Directory Suppress? <input type="checkbox"/> YES <input type="checkbox"/> NO Accepting new patients? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Effective Date: _____		Practicing Specialty at this Site: _____		Primary Site? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> ADD	<input type="checkbox"/> REMOVE	Remove ALL sites for this TIN? YES <input type="checkbox"/> NO <input type="checkbox"/>		Remove Reason: _____	