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 ☐ Other (Please Specify): _____

DOB: _____ Gender: ☐ M - Male ☐ F - Female ☐ X - Unspecified or Another Gender Identity ☐ U - Undisclosed

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 or more categories:

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Middle Eastern or North African ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Prefer not to say ☐ Other (please specify): _____

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:

Address:	City/State:	Zip:

Tax ID:	Type 2 Site NPI:	Directory Suppress: YES ☐ NO ☐	Regularly Sees Patients Here at Least Once Per Week: 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:**

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:	City/State:	Zip:

Tax ID:	Type 2 Site NPI:	Directory Suppress: YES ☐ NO ☐	Regularly Sees Patients Here at Least Once Per Week: 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:**

CHANGE Practitioner Demographic Data

Effective Date of Change:

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

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: _____ MI: _____ NPI: _____

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:

Address:	City/State:	Zip:

Tax ID:	Type 2 Site NPI:	Directory Suppress: YES ☐ NO ☐	Regularly Sees Patients Here at Least Once Per Week: 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 (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:	City/State:	Zip:

Tax ID:	Type 2 Site NPI:	Directory Suppress: YES ☐ NO ☐	Regularly Sees Patients Here at Least Once Per Week: 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 (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:	City/State:	Zip:

Tax ID:	Type 2 Site NPI:	Directory Suppress: YES ☐ NO ☐	Regularly Sees Patients Here at Least Once Per Week: 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 (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 Site NPI:	Directory Suppress: YES ☐ NO ☐	Regularly Sees Patients Here at Least Once Per Week: 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:**