

MINNESOTA UNIFORM PRACTITIONER CHANGE FORM – Revised December 2005

Add – Remove – Change Demographic Data for Credentialed Practitioners and Specialists Not Subject to Credentialing
(ER Physician, Pathologist, Radiologist, Anesthesiologist, CRNA, Neonatologist, Dietitian – *check with entity if unsure*)

Demographic Verification and Authorization

Completed and authorized on behalf of the practitioner by:

Name: _____

Clinic Name: _____

Phone #: _____ FAX #: _____ E-Mail: _____

Signature: _____ Title: _____ Date: _____

Practitioner Demographic Information for this Request

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

Title: MD DO DDS Other Title: _____ DOB: _____
 DC DPM Ph.D Female Male

MN Medicaid ID: _____ UPIN: _____ NPI: _____ DEA: _____

License Number: _____ State: _____ Languages Spoken Fluently: _____

ADD/REMOVE Practitioner

<input type="checkbox"/> Clinic <input type="checkbox"/> Hospital		Clinic/Hospital Name: _____	Phone: _____
Address: _____		City/State: _____	Zip: _____
Tax ID: _____		Directory Suppress? <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 SITE	<input type="checkbox"/> REMOVE SITE	Remove Reason: _____	

List additional practice locations to ADD/REMOVE on the Site Location Addendum and attach to this form.

ADD/REMOVE Practitioner

<input type="checkbox"/> Clinic <input type="checkbox"/> Hospital		Clinic/Hospital Name: _____	Phone: _____
Address: _____		City/State: _____	Zip: _____
Tax ID: _____		Directory Suppress? <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 SITE	<input type="checkbox"/> REMOVE SITE	Remove Reason: _____	

List additional practice locations to ADD/REMOVE on the Site Location Addendum and attach to this form.

ADD/REMOVE Practitioner

<input type="checkbox"/> Clinic <input type="checkbox"/> Hospital		Clinic/Hospital Name: _____	Phone: _____
Address: _____		City/State: _____	Zip: _____
Tax ID: _____		Directory Suppress? <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 SITE	<input type="checkbox"/> REMOVE SITE	Remove Reason: _____	

List additional practice locations to ADD/REMOVE on the Site Location Addendum and attach to this form.

CHANGE Practitioner Demographic Data

Old:	New:
Last Name: _____	Last Name: _____
First Name: _____ MI: _____	First Name: _____ MI: _____
Specialty: _____	Specialty: _____
License #: _____ (Include State)	License #: _____ (Include State)
DEA #: _____	DEA #: _____ (Please attach copy of NEW DEA Certificate to this form)
NPI #: _____	NPI #: _____

Effective Date of Change: _____

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 THREE SITES. MEDICA WILL ONLY ACCEPT THE SITE LOCATION ADDENDUM FORM WHEN IT IS ACCOMPANIED BY A COMPLETED MINNESOTA UNIFORM PRACTITIONER CHANGE FORM.

SITE LOCATION ADDENDUM

Must indicate if the additional site(s) are being ADDED or REMOVED

ADDITIONAL LOCATION(s) FOR:

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

Clinic Name:		Phone:	
Address:	City/State:		Zip:
Tax ID: <small>(if different from page 1)</small>		<u>Directory Suppress?</u> <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 SITE	<input type="checkbox"/> REMOVE SITE	Remove Reason:	

Clinic Name:		Phone:	
Address:	City/State:		Zip:
Tax ID: <small>(if different from page 1)</small>		<u>Directory Suppress?</u> <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 SITE	<input type="checkbox"/> REMOVE SITE	Remove Reason:	

Clinic Name:		Phone:	
Address:	City/State:		Zip:
Tax ID: <small>(if different from page 1)</small>		<u>Directory Suppress?</u> <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 SITE	<input type="checkbox"/> REMOVE SITE	Remove Reason:	

Clinic Name:		Phone:	
Address:	City/State:		Zip:
Tax ID: <small>(if different from page 1)</small>		<u>Directory Suppress?</u> <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 SITE	<input type="checkbox"/> REMOVE SITE	Remove Reason:	