CONNECTED
SENIOR CARE ADVANTAGE

Standardized Group Practice/Individual Provider Update Form

This form is to be utilized for both practice and individual provider updates, additions and deletions. Practice changes REQUIRE a W-9. There are no required forms for individual provider changes. Please fill out all required fields to ensure timely processing. Please allow up to 10 business days for your provider portal to reflect any changes (apart from individual provider additions). If terminating a provider or practice, complete only Sections 1 & 2 and SIGN.

Today's Date:

Section 1: General

Practice Name:	
Practice NPI:	Practice Tax ID:
Individual Provider Name:	
Provider NPI:	
Administrator Name:	Title:
Phone:	Email:

Section 2: Reason for Form Submission

Select all options that apply

- ☐ Add NEW Individual Provider
- ☐ Terminate Individual Provider Effective:
- ☐ Add Additional Practice Location(s)
- ☐ Terminate Practice Location(s) Effective:
- ☐ Report Phone/Email/Fax Changes
- ☐ Practice Name Change
- ☐ Practice Tax ID Change
- ☐ Individual Provider Name Change
- ☐ Other (please describe in section 6)

Section 3: Individual Provider Updates

Only complete this section for individual provider additions and name updates. NEW PROVIDERS REQUIRE ALL FIELDS. Current provider updates require NPI and all applicable fields. New providers will be required to move through the credentialing process, no changes will be reflected on the provider portal until approval is received. To ensure timely approval, please ensure all information is updated through CAQH and allow our credentialing entity, PPMC, access to view your file. Check this box certifying you understand this information. → ☐

NEW NAME (if applicable):	
Credentials:	CAQH #:
If "Other Credential", please specify:	
CAQH Attested w/ in past 60 Days: ☐ Y ☐ N	Attestation Date:
Languages Spoken:	Sex: ◯ M ◯ F
General Certificate/Primary Specialty:	
Fellowship/Subspecialty:	
Practice Locations:	Hospital Affiliations:

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Section 4: Practice Updates

A W-9 is REQUIRED for all practice changes and must be submitted with this form to be considered complete for processing.

☐New	☐Term	☐Update	Effective Date:	
Street Address/PO Box:			Suite #:	
City:		State:		Zip:
County:			NPI if applicable:	
Address Type: ☐Practice ☐W-9 ☐1099 ☐Remit ☐Correspondence ☐Administrative				
☐New	☐Term	☐Update	Effective Date:	
Street Address/PO Box:			Suite #:	
City:		State:		Zip:
County:			NPI if applicable:	
Address Type: ☐Practice ☐W-9 ☐1099 ☐Remit ☐Correspondence ☐Administrative				
☐New	☐Term	☐Update	Effective Date:	
Street Address/PO Box:			Suite #:	
City:		State:		Zip:
County:			NPI if applicable:	
Address Type: ☐Practice ☐W-9 ☐1099 ☐Remit ☐Correspondence ☐Administrative				
☐New	☐Term	☐Update	Effective Date:	
Street Address/PO Box:			Suite #:	
City:		State:		Zip:
County:			NPI if applicable:	
Address Type: ☐Practice ☐W-9 ☐1099 ☐Remit ☐Correspondence ☐Administrative				
☐New	☐Term	☐Update	Effective Date:	
Street Address/PO Box:			Suite #:	
City:		State:		Zip:
County:			NPI if applicable:	
Address Type: ☐Practice ☐W-9 ☐1099 ☐Remit ☐Correspondence ☐Administrative				

Section 5: Practice Contact Updates

New Phone:	New Email:
New Fax:	New Website:

Section 6: Comments

Print Name: _____

Sign Name: _____

Date: _____

Please PRINT, SIGN and SCAN form with supporting documents to

EMAIL: CSCAContracting@connectedseniorcare.com
FAX: 512-960-1193
or **MAIL** to:
Connected Senior Care Advantage
6210 U.S. Hwy 290 E., Suite 450
Austin, TX 78723

For new providers, the credentialing process can take up to 45 days from receipt of request to reflect on our provider portal.

For all other changes, please allow up to 30 days from receipt of request to reflect on our provider portal.