

**MINNESOTA UNIFORM PRACTITIONER CHANGE FORM - Revised April 2022**

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**

\*\*\*\*\*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: \_\_\_\_\_

**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	Native Hawaiian or Other Pacific Islander	Hispanic or Latino
	Asian	White	Prefer not to say
	Black or African American	Other:	

**ADD/REMOVE Practitioner**

Practicing as:  Primary Care  Specialist  Urgent Care  Locum Tenens  Hospitalist/Hospital-based

Teaching/Research only  Moonlighting Resident  Other

Clinic  Hospital Clinic/Hospital Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tax ID: _____	Type 2 Site NPI: _____	Directory Suppress? <input type="checkbox"/> YES <input type="checkbox"/> NO	Regularly Sees Patients Here at Least Once Per Week? YES <input type="checkbox"/> *NO <input type="checkbox"/>	Accepting New Patients? YES <input type="checkbox"/> NO <input type="checkbox"/>
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Effective Date: _____	Practicing Specialty at this Site: _____	Primary Site? <input type="checkbox"/> YES <input type="checkbox"/> NO
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<b>ADD</b>	<b>REMOVE</b>	Remove ALL sites for this TIN? <b>YES</b> <b>NO</b>	<b>Remove Reason:</b> _____
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Practicing as:  Primary Care  Specialist  Urgent Care  Locum Tenens  Hospitalist/Hospital-based

Teaching/Research only  Moonlighting Resident  Other

Clinic  Hospital Clinic/Hospital Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tax ID: _____	Type 2 Site NPI: _____	Directory Suppress? <input type="checkbox"/> Yes <input type="checkbox"/> No	Regularly Sees Patients Here at Least Once Per Week? YES <input type="checkbox"/> *NO <input type="checkbox"/>	Accepting New Patients? YES <input type="checkbox"/> NO <input type="checkbox"/>
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Effective Date: _____	Practicing Specialty at this Site: _____	Primary Site? <input type="checkbox"/> YES <input type="checkbox"/> NO
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<b>ADD</b>	<b>REMOVE</b>	Remove ALL sites for this TIN? <b>YES</b> <b>NO</b>	<b>Remove Reason:</b> _____
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**CHANGE Practitioner Demographic Data**

**Effective Date of Change:** \_\_\_\_\_

<b>Old:</b>	<b>New:</b>
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: <input type="checkbox"/> Primary Care <input type="checkbox"/> Specialist <input type="checkbox"/> Urgent Care <input type="checkbox"/> Locum Tenens <input type="checkbox"/> Hospitalist/Hospital-based					
<input type="checkbox"/> Teaching/Research only <input type="checkbox"/> Moonlighting Resident <input type="checkbox"/> Other					
<input type="checkbox"/> Clinic <input type="checkbox"/> Hospital    Clinic/Hospital Name: _____					
Address: _____			City/State: _____		Zip: _____
Tax ID: _____	Type 2 Site NPI: _____	Directory Suppress? <input type="checkbox"/> YES <input type="checkbox"/> NO	Regularly Sees Patients Here at Least Once Per Week? YES <input type="checkbox"/> *NO <input type="checkbox"/>	Accepting New Patients? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Effective Date: _____	Practicing Specialty at this Site: _____		Primary Site? <input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>ADD</b>	<b>REMOVE</b>	Remove ALL sites for this TIN? <b>YES</b> <b>NO</b>		<b>Remove Reason:</b> _____	

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"/> Hospitalist/Hospital-based					
<input type="checkbox"/> Teaching/Research only <input type="checkbox"/> Moonlighting Resident <input type="checkbox"/> Other					
<input type="checkbox"/> Clinic <input type="checkbox"/> Hospital    Clinic/Hospital Name: _____					
Address: _____			City/State: _____		Zip: _____
Tax ID: _____	Type 2 Site NPI: _____	Directory Suppress? <input type="checkbox"/> YES <input type="checkbox"/> NO	Regularly Sees Patients Here at Least Once Per Week? YES <input type="checkbox"/> *NO <input type="checkbox"/>	Accepting New Patients? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Effective Date: _____	Practicing Specialty at this Site: _____		Primary Site? <input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>ADD</b>	<b>REMOVE</b>	Remove ALL sites for this TIN? <b>YES</b> <b>NO</b>		<b>Remove Reason:</b> _____	

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"/> Hospitalist/Hospital-based					
<input type="checkbox"/> Teaching/Research only <input type="checkbox"/> Moonlighting Resident <input type="checkbox"/> Other					
<input type="checkbox"/> Clinic <input type="checkbox"/> Hospital    Clinic/Hospital Name: _____					
Address: _____			City/State: _____		Zip: _____
Tax ID: _____	Type 2 Site NPI: _____	Directory Suppress? <input type="checkbox"/> YES <input type="checkbox"/> NO	Regularly Sees Patients Here at Least Once Per Week? YES <input type="checkbox"/> *NO <input type="checkbox"/>	Accepting New Patients? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Effective Date: _____	Practicing Specialty at this Site: _____		Primary Site? <input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>ADD</b>	<b>REMOVE</b>	Remove ALL sites for this TIN? <b>YES</b> <b>NO</b>		<b>Remove Reason:</b> _____	

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"/> Hospitalist/Hospital-based					
<input type="checkbox"/> Teaching/Research only <input type="checkbox"/> Moonlighting Resident <input type="checkbox"/> Other					
<input type="checkbox"/> Clinic <input type="checkbox"/> Hospital    Clinic/Hospital Name: _____					
Address: _____			City/State: _____		Zip: _____
Tax ID: _____	Type 2 Site NPI: _____	Directory Suppress? <input type="checkbox"/> YES <input type="checkbox"/> NO	Regularly Sees Patients Here at Least Once Per Week? YES <input type="checkbox"/> *NO <input type="checkbox"/>	Accepting New Patients? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Effective Date: _____	Practicing Specialty at this Site: _____		Primary Site? <input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>ADD</b>	<b>REMOVE</b>	Remove ALL sites for this TIN? <b>YES</b> <b>NO</b>		<b>Remove Reason:</b> _____	