

MEDIPASS CHANGE OF STATUS FORM

Practice Name: _____

Doing Business As: _____

Service Location Address: _____

Provider Medicaid Number: _____

If any changes occur in your MediPass practice, please complete and send this form to:

[Click here](#) for a list of your local MediPass office addresses.

If you need additional instructions to complete this form, [click here](#)

1. PRACTICE NAME

IF YOUR PRACTICE NAME HAS CHANGED, PLEASE INDICATE THE NEW NAME IN THE SPACE BELOW:

2. SERVICE LOCATION:

IF YOUR PRACTICE LOCATION HAS CHANGED, PLEASE INDICATE BELOW:

| ADDRESS | CITY | ZIP | TELEPHONE |
|---------|------|-----|-----------|
|---------|------|-----|-----------|

3. MAIL TO/ CORRESPONDENCE ADDRESS:

IF YOUR MAILING ADDRESS HAS CHANGED, PLEASE INDICATE BELOW:

| ADDRESS | CITY | ZIP | TELEPHONE |
|---------|------|-----|-----------|
|---------|------|-----|-----------|

4. OTHER ADDRESS CHANGE: PAY TO HOME/CORPORATE OFFICE:

| ADDRESS | CITY | ZIP | TELEPHONE |
|---------|------|-----|-----------|
|---------|------|-----|-----------|

5. HOURS OF OPERATION

Weekday Hours _____

Weekend Hours _____

6. PATIENT ENROLLMENT CAP

I WANT TO CHANGE MY MEDIPASS PATIENT ENROLLMENT CAP TO: _____
(NOT TO EXCEED 1500 PER EACH FULL TIME PHYSICIAN AND 750 PER EACH FULL TIME ARNP OR PA)

7. MANAGED CARE FOCUS AND AGE LIMIT

INDICATE THE PRIMARY CARE SPECIALITY THAT IS PRACTICED AT YOUR OFFICE: (General Practice, Family Practice, Pediatrics, Internal Medicine, Obstetrics, Gynecology)

INDICATE THE MINIMUM AND MAXIMUM PATIENT AGE RANGE YOUR PRACTICE WISHES TO SEE:

8. PHYSICIAN, ARNP OR PA CHANGES OR ADDITIONS

PLEASE INDICATE PHYSICIANS, ARNPs OR PAs THAT HAVE BEEN ADDED TO YOUR MEDIPASS PRACTICE; OR ANY CHANGES FOR CURRENT MEMBERS:

- A. TYPED NAME, DEGREE;
- B. PROVIDER NUMBER;
- C. DATE OF BIRTH
- D. SOCIAL SECURITY NUMBER
- E. WEEKLY HOURS PER LOCATION (i.e. 20 HOURS);
- F. PRIMARY CARE SPECIALTY;
- G. LOCATION;
- H. SIGNATURE;
- I. PROVIDER OR EXTENDER
- J. DATE SIGNED

| | | | |
|----|----------|----|----------|
| 1. | A. _____ | 2. | A. _____ |
| | B. _____ | | B. _____ |
| | C. _____ | | C. _____ |
| | D. _____ | | D. _____ |
| | E. _____ | | E. _____ |
| | F. _____ | | F. _____ |
| | G. _____ | | G. _____ |
| | H. _____ | | H. _____ |
| | I. _____ | | I. _____ |
| | J. _____ | | J. _____ |

9. PHYSICIAN, ARNP OR PA DELETIONS

PLEASE INDICATE ANY PHYSICIANS, ARNPs OR PAs THAT ARE NO LONGER WITH YOUR MEDIPASS PRACTICE:

| | A. TYPED NAME | B. PROVIDER NUMBER |
|----|---------------|--------------------|
| 1. | A. _____ | B. _____ |
| 2. | A. _____ | B. _____ |
| 3. | A. _____ | B. _____ |
| 4. | A. _____ | B. _____ |

Authorized Signature

Date