First Choice Health®

Provider Update Form

Please note: This form is intended for providers who are already credentialed with FCH. If you would like to become credentialed with FCH, please visit www.fchn.com/Providers and click on the Network Participation link.

Contact Name (First Name):	Contact Phone:	Contact E-mail Address:	Effective Date of Change:
Provider Name:		Provider NPI:	Taxonomy:

TYPE OF PROVIDER CHANGE: ☐ ADD ☐ REMOVE		Tax ID Number:	
Street Address:	City:	State:	Zip Code + Four:
Check Appropriate Type of Address: ☐ Physical Practice Address (not PO Box) ☐ Billing ☐ Mailing ☐ Credentialing		Phone Number:	
Hospital Affiliation:	Languages Spoken (other than English):	Address ADA Accessible: ☐ Yes ☐ No	
☐ Women's Health ☐ OB Deliveries ☐ Telemedicine	Capacity (maximum number of patients that practitioner manages):		

TYPE OF ADDRESS CHANGE: ☐ ADD ☐ REMOVE		Tax ID Number:	
Street Address:	City:	State:	Zip Code + Four:
Check Appropriate Type of Address: ☐ Physical Practice Address (not PO Box) ☐ Billing ☐ Mailing ☐ Credentialing		Phone Number:	
Hospital Affiliation:	Languages Spoken (other than English):	Address ADA Accessible: ☐ Yes ☐ No	
Gender Limitations: ☐ Male ☐ Female ☐ None	Minimum Age:	Maximum Age:	
☐ Women's Health ☐ OB Deliveries ☐ Telemedicine	Capacity (maximum number of patients that practitioner manages):		

TYPE OF ADDRESS CHANGE: ☐ ADD ☐ REMOVE		Tax ID Number:	
Street Address:	City:	State:	Zip Code + Four:
Check Appropriate Type of Address: ☐ Physical Practice Address (not PO Box) ☐ Billing ☐ Mailing ☐ Credentialing		Phone Number:	
Hospital Affiliation:	Languages Spoken (other than English):	Address ADA Accessible: ☐ Yes ☐ No	
Gender Limitations: ☐ Male ☐ Female ☐ None	Minimum Age:	Maximum Age:	
☐ Women's Health ☐ OB Deliveries ☐ Telemedicine	Capacity (maximum number of patients that practitioner manages):		

Pay-To Address: As a Preferred Provider Organization (PPO), we do not store your pay-to address (where you want your checks to be sent) in our system. This address should be relayed on your claims. For electronic (EDI) claims, submit this address in loop 2010 AB, and on a paper claim (CMS 1500 or HCFA), this address should be in box 33.

OTHER CHANGES: ☐ CORPORATE ☐ PERSONAL		
Changes in this section assume that no other changes are needed. For example, if the information provided below is the Old and New Tax ID Number, we will update only the Tax ID Number and no other changes to existing information will be made.		
	OLD	NEW
☐ Corporate Name **(W-9 form required)**		
☐ Tax ID Number **(W-9 form required)**		
☐ Personal Name		
☐ Individual NPI Number		
☐ Phone (Practice location)		
☐ Fax (Practice location)		

SUBMISSION INSTRUCTIONS:

Complete the form, download or save a copy, and send it (including W-9 and other pertinent documentation as needed) as an email attachment to ppofilemaintenance@fchn.com, indicating 'Provider Update' in the subject line. (NOTE: If your internet browser does not allow typing in the fillable form, you must download the form and use free Adobe Acrobat Reader software to complete it.)

If you are unable to email the form, send it via fax to (206) 268-2940, ATTN: Provider Information Department.

Any changes sent to our Provider Information team will take approximately 30 business days to implement.