MOUNTAIN HEALTH CO-OP

Provider/Practice Update Form

Please email this completed form to **mhc-plm-ops@wipro.com**. Complete all relevant fields for either provider or practice updates in the appropriate sections. Please include any associated provider(s) and NPI number(s) that must be listed under the change. You may include a roster of providers with this form. This information is required to complete this request.

Provider Update

Effective Date of Change _____ ☐ **Change Information**

Group Name _____

Group Tax ID _____ **Group NPI** _____ **Individual NPI** _____

Name _____

New Name (if Applicable) _____

Provider Gender _____

Email _____ Phone_____

Practice Update

Effective Date of Change _____ ☐ **Change Information** ☐ **Add New Location**

Group Tax ID _____ **Group NPI** _____

New Group NPI(s) (if applicable) _____

Practice Location Name _____
(For Patient Visits and Directory Listing)

New Name (if applicable) _____

Associated Provider Name_____ NPI_____
(Applicable if affiliated with new location(s). If multiple providers, please include a roster with your email)

Email _____ Fax_____

Old Physical Address _____

Phone _____ Fax_____

New Physical Address _____

Phone _____ Fax_____

Old Billing Address _____

Phone _____ Fax_____

New Billing Address _____

Phone _____ Fax_____

Location Information (Please check any that apply to the office location)

☐ Extended Hours ☐ Mental Health Treatment ☐ Domestic Violence Support Available

☐ Pediatric Services ☐ Handicap Accessible ☐ Substance Use Treatment

☐ Virtual Visits ☐ Hearing Impairment Accommodations

☐ Visual Impairment Accommodations

Gender Restriction (If any) _____ Age Restriction (If any) _____

Cultural Competency Training Date _____

Website URL _____

Website URL: By providing the URL to your clinic website, you give Mountain Health CO-OP permission to publish a link to your site in our provider directories. Mountain Health CO-OP assumes no responsibility or liability for the information displayed on your site.