Practice Profile Update Form

To update your practice profile, email a completed form with the new information to the Provider Data Management department at MOProviderData@Anthem.com. If you have any questions or need assistance, contact your local Network Relations consultant.

Please note:

- Do not complete the entire form; only fill in sections where your information has changed.
- You must complete the **Provider information** section.
- Sign and date the form before emailing.

Provider information			
Provider name:		License number:	
Provider type:	☐ PCP ☐ Specialist	Provider NPI:	
Gender:	☐ Female ☐ Male	Taxonomy number:	
Specialty:		MO HealthNet ID:	

What type of information are you updating? *Check all that apply.*

☐ Billing information ☐ Primary care provider details ☐ Office hours
☐ Practice details ☐ Location or contact information ☐ Other (explain):

Primary care provider details

Primary care providers are ***required*** to have coverage 24/7. Please mark your coverage type:

☐ Answering service ☐ Answering machine
☐ Other phone number:

_____

Are you accepting new patients? ☐ Yes ☐ No
If yes, please explain (for example, at all locations):

_____

Do you have *Clinical Laboratory Improvement Amendments (CLIA)* certification? ☐ Yes ☐ No
If yes, please provide level of certification, *CLIA* certification number, and effective and expiration dates:

Billing information — *Attach a copy of your current* W-9 *for all billing information changes.*

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New/additional office location(s)			
☐ New practice location ☐ Additional covering location		Group NPI:	
Site name:			
Site address:			
Website:			
Office manager/email address:			
Phone number:		Fax number:	

Above location is a CMS or State designated (only complete if applicable):

☐ Provider-based rural health clinic: RHC NPI:_____ Non-RHC NPI:_____

☐ Independent rural health clinic: RHC NPI:_____ Non-RHC NPI:_____

☐ Federally qualified health center: FQHC NPI:_____

☐ Community mental health center (Designated by MO Department of Mental Health): CMHC NPI:_____

Billing name:		
Billing address:		
Tax ID:	Billing NPI:	
Billing number:		

Office hours:		
Monday	a.m.	p.m.
Tuesday	a.m.	p.m.
Wednesday	a.m.	p.m.
Thursday	a.m.	p.m.
Friday	a.m.	p.m.
Saturday	a.m.	p.m.
Sunday	a.m.	p.m.

Age range of patients served:

☐ Pediatric ☐ Geriatric: _____

☐ 0 to 21 ☐ 21 and older

☐ All ages ☐ Other: _____

Languages spoken: _____

Wheelchair accessible? ☐ Yes ☐ No

Remove an office location	
Do you want to remove an office location? ☐ Yes ☐ No	
Site name:	
Site address:	
Office manager/email address:	
Phone number:	
Fax number:	

To add or remove additional office locations, attach a separate sheet.

Signature:		***For office use only***	
Printed name:		Date completed:	
Contact phone number:		Date received by Healthy Blue:	