

**MINNESOTA UNIFORM PRACTITIONER CHANGE FORM – Revised December 2005**

Add – Remove – Change Demographic Data for Credentialed Practitioners and Specialists Not Subject to Credentialing (ER Physician, Pathologist, Radiologist, Anesthesiologist, CRNA, Neonatologist, Dietitian – *check with entity if unsure*)

**Demographic Verification and Authorization**

**Completed and authorized on behalf of the practitioner by:**

Name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ FAX #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

**Practitioner Demographic Information for this Request**

Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ SSN: \_\_\_\_\_

Title:  MD  DO  DDS  Other Title: \_\_\_\_\_ DOB: \_\_\_\_\_

DC  DPM  Ph.D  Female  Male

MN Medicaid ID: \_\_\_\_\_ UPIN: \_\_\_\_\_ NPI: \_\_\_\_\_ DEA: \_\_\_\_\_

License Number: \_\_\_\_\_ State: \_\_\_\_\_ Languages Spoken Fluently: \_\_\_\_\_

**ADD/REMOVE Practitioner**

<input type="checkbox"/> Clinic <input type="checkbox"/> Hospital		Clinic/Hospital Name: _____	Phone: _____
Address: _____		City/State: _____	Zip: _____
Tax ID: _____		Directory Suppress? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Effective Date: _____	Practicing Specialty at this Site: _____		Primary Site? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ADD SITE	<input type="checkbox"/> REMOVE SITE	Remove Reason: _____	

List additional practice locations to ADD/REMOVE on the Site Location Addendum and attach to this form.

**ADD/REMOVE Practitioner**

<input type="checkbox"/> Clinic <input type="checkbox"/> Hospital		Clinic/Hospital Name: _____	Phone: _____
Address: _____		City/State: _____	Zip: _____
Tax ID: _____		Directory Suppress? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Effective Date: _____	Practicing Specialty at this Site: _____		Primary Site? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ADD SITE	<input type="checkbox"/> REMOVE SITE	Remove Reason: _____	

List additional practice locations to ADD/REMOVE on the Site Location Addendum and attach to this form.

**ADD/REMOVE Practitioner**

<input type="checkbox"/> Clinic <input type="checkbox"/> Hospital		Clinic/Hospital Name: _____	Phone: _____
Address: _____		City/State: _____	Zip: _____
Tax ID: _____		Directory Suppress? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Effective Date: _____	Practicing Specialty at this Site: _____		Primary Site? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ADD SITE	<input type="checkbox"/> REMOVE SITE	Remove Reason: _____	

List additional practice locations to ADD/REMOVE on the Site Location Addendum and attach to this form.

**CHANGE Practitioner Demographic Data**

<b>Old:</b> Last Name: _____	<b>New:</b> Last Name: _____
First Name: _____ MI: _____	First Name: _____ MI: _____
Specialty: _____	Specialty: _____
License #: _____ (Include State)	License #: _____ (Include State)
DEA #: _____	DEA #: _____ (Please attach copy of NEW DEA Certificate to this form)
NPI #: _____	NPI #: _____

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