

ASPIRUS UNIFORM PRACTITIONER CHANGE FORM

Add – Remove – Change Demographic Data for Credentialed Practitioners and Specialists Not Subject to Credentialing: ER Physician, Pathologist, Radiologist, Anesthesiologist, CRNA, Neonatologist, Dietitian, Therapists (PT;OT; SLP), Audiologist – *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

DEA: _____ State: _____ Type I NPI: _____ Medicaid ID: _____ State: _____

License Number: _____ State: _____ Languages Spoken Fluently: _____

ADD/REMOVE Practitioner

☒ Clinic ☐ Hospital Clinic/Hospital Name: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Tax ID: _____ Type 2 NPI for this site: _____ Directory Suppress? ☐ YES ☒ NO

Effective Date: _____ Practicing Specialty at this Site: _____ Primary Site? ☐ YES ☒ NO

☐ ADD ☐ REMOVE Remove ALL sites for this TIN? YES ☐ NO ☐ Remove Reason: _____

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

ADD/REMOVE Practitioner

☐ Clinic ☐ Hospital Clinic/Hospital Name: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Tax ID: _____ Type 2 NPI for this site: _____ Directory Suppress? ☐ YES ☒ NO

Effective Date: _____ Practicing Specialty at this Site: _____ Primary Site? ☐ YES ☐ NO

☐ ADD ☐ REMOVE Remove ALL sites for this TIN? YES ☐ NO ☐ Remove Reason: _____

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

ADD/REMOVE Practitioner

☐ Clinic ☐ Hospital Clinic/Hospital Name: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Tax ID: _____ Type 2 NPI for this site: _____ Directory Suppress? ☐ YES ☒ NO

Effective Date: _____ Practicing Specialty at this Site: _____ Primary Site? ☐ YES ☐ NO

☐ ADD ☐ REMOVE Remove ALL sites for this TIN? YES ☐ NO ☐ Remove Reason: _____

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

CHANGE Practitioner Demographic Data

Old: Last Name: _____ **New:** 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)

Type I NPI #: _____ Type I NPI #: _____

Effective Date of Change: _____

Return completed, signed form via: Email: Credentialingahp@optum.com or Fax to: 763.847.4814.