Please use the attached Provider/Facility Change Form to report any changes to your organization. This will help ensure payment and directory accuracy.

Scan and email the form to: ProviderSupport@vibrahealthplan.com.

Request Changes to Provider/Facility Information

Questions call toll-free 844.440.4629.

Facility Legal Name / DBA (required):
Facility Federal Tax ID (required):

****PLEASE UPDATE CHANGES ONLY****

Type of Change:_____ **Effective date of changes:**_____

Facility Legal Name / Facility DBA:		
Provider/Facility NPI (Type 2):		
Facility Website:		
Primary Contact Name:	Phone #:	E-mail:
Billing/Credentialing Contact Name:	Phone #:	E-mail:
Billing/payment Address:	Phone #:	Fax #:

Provider/Facility Location(s) – physical location where patients receive services.

Address	Phone	Fax	TIN #	CCN #	Add	Delete
1) Primary:					☐	☐
2) Additional:					☐	☐
3) Additional:					☐	☐

Please indicate counties where services are provided (if applicable).

Adams	☐	Chester	☐	Huntingdon	☐	Mifflin	☐	Pike	☐	Wayne	☐
Berks	☐	Clinton	☐	Juniata	☐	Monroe	☐	Potter	☐	Wyoming	☐
Bucks	☐	Columbia	☐	Lackawanna	☐	Montgomery	☐	Schuylkill	☐	York	☐
Bedford	☐	Cumberland	☐	Lancaster	☐	Montour	☐	Snyder	☐		
Blair	☐	Dauphin	☐	Lebanon	☐	Northampton	☐	Sullivan	☐		
Bradford	☐	Delaware	☐	Lehigh	☐	Northumberland	☐	Susquehanna	☐		
Carbon	☐	Franklin	☐	Luzerne	☐	Perry	☐	Tioga	☐		
Centre	☐	Fulton	☐	Lycoming	☐	Philadelphia	☐	Union	☐		

_____ _____ _____ _____

Signature of Authorized Representative | Title | Date | Phone #