Please use the attached Practice/Physician Change Form to report any changes to your practice. This will help ensure payment and directory accuracy.

Scan and email the form to (preferred): **ProviderSupport@vibrahealthplan.com**

or Mail to: Vibra Health Plan
P.O. Box 60250
Harrisburg, PA 17106-0250

or Fax to: 1-717-963-7734

If you have any questions, please contact us at:
Email: ProviderSupport@vibrahealthplan.com
Phone: 1-717-510-6301
Toll Free: 1-844-440-4629

Request Changes to Practice/Physician Information

Return to: ProviderSupport@vibrahealthplan.com or Fax 717-963-7734 or Vibra Health Plan, PO Box 60250, Harrisburg, PA 17106-0250 Questions call toll free (844) 440-4629

Practice Name (required):	Practice Tax ID Number (required):

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

PRACTICE INFORMATION:

Practice Name:			
Practice Tax ID Number:	Practice NPI (Type 2):		
Practice Website:			
Primary Contact Name:	Primary Contact Email Address:		
Mailing Address (for correspondence):	Phone:	Fax:	
Billing/Payment Address:	Phone:	Fax:	

Practice Location(s) – physical location where patients receive service	Handicap Accessible (Y/N)	Phone Number	Fax Number
1) Primary Location:			
2) Additional Location:			
3) Additional Location:			
4) Additional Location:			

PHYSICIAN/PROVIDER INFORMATION:

*Add	Delete	Eff Date	Provider Name(s)	Gender *(M/F)*	Date of Birth	Prof. Deg *(MD, DO)*	Provider NPI (Type 1)	CAQH #	Specialty(ies) *(IM, Fam Prac, etc)*	Hospital Privileges *(Names of Hospitals)*	Practice Location #	Accept New Patients Y/N	Hospital Based Y/N	PCP Y/N

Newly added providers will require VHP credentialing

_____ _____ _____ _____

Signature of Authorized Representative | Title | Date | Phone #