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: ProviderSupport@vibrahealthplan.com.

Request Changes to Practice/Physician Information

Return to: ProviderSupport@vibrahealthplan.com. 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(ites) (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 #

VHP-311 (09/15/21)