PEHP Provider Information Update Form

Complete this form to make updates to your provider or group information with PEHP. Select all applicable changes that apply. Allow a minimum of 14 business days for processing. For larger submissions, please use our Roster Form.

Section 1: Request Type

*Select all that apply:

- ☐ Update Demographic Information (e.g., address, phone, email, service location)
- ☐ Out-of-Network Provider Submitting Claims (List only practitioners and/or locations that have rendered services to a PEHP member)
- ☐ Update Clearinghouse Information (for electronic claims submission)
- ☐ Returned Check Notification – Updating billing address for reissued payment

**To avoid delays and paper check fees, we recommend setting up direct deposit. Your Local Admin can log into your PEHP provider account, go to Resources, and complete the Provider EFT Form.*

Effective Date of Change: _____

Section 2: Group/Facility Information

Tax ID Number: _____ *Attach W9 form with the legal name reported to IRS*		
Clinic/Facility Name:		
Billing address:		☐ This is a new address
Street:		
City:	State:	Zip:
Clearinghouse Name/Trading Partner ID (UHIN-Include HT prefix)*: ** Required for electronic claims setup or clearinghouse changes*		
Service Location Address:		
☐ New address	☐ Adding an Additional Service Location	☐ Relocated – Previous Address Closed
Street:		
City:	State:	Zip:
Previous Address (if applicable):		
Street:		
City:	State:	Zip:
Location Phone:	Email: *For PEHP newsletters and other updates*	

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Section 2: Group/Facility Information (continued)			
Primary Correspondence Address:			
☐ Same as billing address		☐ Same as physical address *(If more than one, coment below)*	
☐ Other:			
Street:	City:	State:	Zip:
Phone Number: _____ ☐ Billing ☐ Other ☐ Additional Phone			
Email: _____ ☐ Billing ☐ Other ☐ Add additional Email Address			

Additional Location (if applicable)		
Service Location Address:		
☐ Adding an Additional Service Location		
Street:		
City:	State:	Zip:
Previous Address (if applicable):		
Street:		
City:	State:	Zip:
Location Phone:	Email: _____ *For PEHP newsletters and other updates*	

Additional Location (if applicable)		
Service Location Address:		
☐ Adding an Additional Service Location		
Street:		
City:	State:	Zip:
Previous Address (if applicable):		
Street:		
City:	State:	Zip:
Location Phone:	Email: _____ *For PEHP newsletters and other updates*	

Provider Information Update Form

Additional Practitioner (if applicable)		
Practitioner Name:		
NPI Number:	Taxonomy Code:	
Service Address:		
City:	State:	Zip:
Phone Number:		

Additional Practitioner (if applicable)		
Practitioner Name:		
NPI Number:	Taxonomy Code:	
Service Address:		
City:	State:	Zip:
Phone Number:		

Additional Practitioner (if applicable)		
Practitioner Name:		
NPI Number:	Taxonomy Code:	
Service Address:		
City:	State:	Zip:
Phone Number:		

Additional Practitioner (if applicable)		
Practitioner Name:		
NPI Number:	Taxonomy Code:	
Service Address:		
City:	State:	Zip:
Phone Number:		

Additional Practitioner (if applicable)		
Practitioner Name:		
NPI Number:	Taxonomy Code:	
Service Address:		
City:	State:	Zip:
Phone Number:		

Provider Information Update Form

Section 4: Contact Person for This Submission
Name:
Title/Role:
Email:
Submission Date:

Section 5: Clarifying Comments
Use this space to explain any special circumstances or provide additional details: