
HealthChoice

NETWORK PROVIDER FACILITY CREDENTIALING INFORMATION

Update Forms, Change Forms and Add Location Forms

Change of Address

- Send the old address with the new address. The old address information must be removed from our system when updating provider information with a new address.
- All three addresses, service, mailing and billing, must be provided for the new location.

Change of Tax ID Number

- A completed and signed W-9 form must accompany all tax ID number changes. The old tax ID number should be supplied to terminate the old number and activate the new identification number.

Address Classifications

- **Service Address**-This address is used for the physical location of the provider and/or the location where health care services are performed. The service address will be used for the on-line provider directory which is used by members and providers to identify and locate all HealthChoice Network Providers
- **Mailing Address**-This address is used for all correspondence and credentialing information.
- **Billing Address**-This address is used for submitting all claims to HealthChoice for processing and appears in box 33 of the CMS-1500 claim form or box 1/2 on the UB-04 claim form. Claims will be paid exclusively to the billing address. Please also include the name which claims will be submitted under.

Insurance Certificate or Face Sheet

Insurance Certificate must specifically indicate that the applicant is the insured, insurance limits must be at the level required by the contract and clearly state that it is for professional/general liability coverage. Product liability insurance is acceptable for DME only.

It is vital that you notify HealthChoice Provider Relations immediately regarding any changes to the service, mailing or billing addresses to prevent delays in receiving notifications regarding the plan's schedule of benefits, the fee schedule and the issuance of claim payments.

Claim and eligibility information is available through the new HealthChoice Provider Web Site at www.sib.ok.gov/providers. Click on "Claim Link" on the left column to go to the EDS web site. Register for user ID and password. Information regarding claim edits is also available at this site.

Network Facility Update Form

Facility Name: _____

Classification: _____ NPI: _____

Tax ID #: _____

Medicare #: _____

Physical Address

Mailing Address

Phone: () _____

Fax: () _____

Contact Person: _____

Email Address: _____

Phone: () _____

Fax: () _____

Contact Person: _____

Email Address: _____

Billing Address

Important Facility Contacts

CEO/Administrator: _____

Phone: () _____

Fax: () _____

Email Address: _____

Contracting/Managed Care: _____

Phone: () _____

Fax: () _____

Email Address: _____

Phone: () _____

Fax: () _____

Contact Person: _____

Email Address: _____

License/Accreditation

Professional Liability Insurance

State of Licensure: _____

License Number: _____

Expiration Date: _____

JCAHO Accredited? Yes No

If Yes, JCAHO Program ID Number: _____

Expiration Date: _____

Carrier Name: _____

Coverage Amounts:

Per Occurrence: _____

Aggregate: _____

Expiration Date: _____

Attachments

Additional Locations

Please attach a copy of each of the following documents that are applicable to your facility:

Current License (if applicable)

W9 Form that is fully completed

Face sheet of current professional liability insurance policy for the facility showing policy number, per occurrence/aggregate limits and expiration date

DUPLICATE AND COMPLETE THIS FORM FOR EACH ADDITIONAL LOCATION

CHANGES

Have you had any address changes in the past year? Yes No

If yes, did your Tax ID # change with this new address? Yes No

Previous Tax ID #: _____

Termination Date of this Tax ID #: _____

Previous Physical Address

Previous Billing Address

Phone: _____ ()

Fax: _____ ()

Contact Person: _____

Email Address: _____

Phone: _____ ()

Fax: _____ ()

Contact Person: _____

Email Address: _____

By signing below, the facility certified the information provided in this form and its attachments and reacknowledges understanding and acceptance of all terms and conditions contained in the current contract.

CEO/Administrator Signature

Signature Date

Print Name

Return To:

Oklahoma State and Education
Employees Group Insurance Board
Attn: Provider Relations/Network Management
3545 N.W. 58th Street, Suite 600
Oklahoma City, OK 73112

Phone: (405) 717-8860
(800) 848-8121

Fax: (405) 717-8977