Change Termination Form

Please list only the information that is being changed, old and new. Submit one form for each provider being changed. If you need to terminate from a group because you are joining a new group, please complete a new HCAS Form for the new group.

Provider Information	Type of Request
INDIVIDUAL/FACILITY	☐ Change Provider Information
NPI	☐ Change to affect multiple providers / locations
TAX ID	☐ Provider Termination (see next form that follows)
EFFECTIVE DATE	
(List of affected providers attached)	

Demographic Information	
Current	**New**
Provider / Group NPI	Provider / Group Name
Individual / Facility NPI	Individual / Facility NPI
Practice Address (Current)	Practice Address (New)
City (Current)	City (New)
State (Current)	State (New)
Zip Code (Current)	Zip Code (New)
Phone Number (Current)	Phone Number (New)
Fax Number (Current)	Fax Number (New)

Remit Address (Current)	Remit Address (New)
City (Current)	City (New)
State (Current)	State (New)
Zip Code (Current)	Zip Code (New)
Phone Number (Current)	Phone Number (New)
Fax Number (Current)	Fax Number (New)

Tax Information – Please attach a copy of the W-9 when making changes.

TAX ID (Current)	TAX ID (New)
TIN Name (Current)	TIN Name (New)

Additional Provider Information

OFFICE HOURS

Monday	Tuesday	Wednesday	Thursday
Friday		Saturday	Sunday

DISABLED ACCESS?

☐ Yes ☐ No

☐ Accessible via Public Transportation	☐ Handicap Accessibility	☐ Handicap Parking Available
☐ Handicap Parking Accessible bathrooms	☐ Elevators in Multistory Buildings	☐ Wheelchair Ramps

Patient Ages

_____to _____ _____ to _____

Languages Spoken in Addition to English	School Based Health Center	
PCP Coverage Information (Attach Additional if Needed)	Hospital Affiliations	
Contract and Payment Information	**Provider Specialties**	
PCP?	Specialty	Subspecialty
PCP Panel Status	Specialty	Subspecialty
Hospitalist	Additional Specialties	
Termination – Please complete Provider Termination Notification Form that follows		
Form Completed By (Name, Title)	Form Completed Date	
Mailing Contact Name	Mailing Contact Email Address	
Internal Use Only		
PPC Rep Making Changes	Date Change Completed	

Submit via Email: ProviderProcessingCenter@wellsense.org

Submit via Fax: 617-897-0818

Provider Termination Change Form

30 Day Notice Required

Provider Name	Provider NPI
Entity Name	Entity TIN
Termination Effective Date *WellSense will use today's date if the date is in the past	Termination Reason
Will Provider Still Practice in Massachusetts? ☐ Yes ☐ No	
If PCP, who will assume the patient panel?	Is Provider within the same group?
Name of Provider Assuming Patient panel	TIN
Name of Person Competing Form	Title of Person Completing Form

As a result of this provider terminating from the WellSense Provider Network, the following steps will take place:

1. Provider will be terminated from the WellSense Provider Network upon receipt.
    a. Received Date to be used as the termination date; Future Date will be used if requested
2. Provider will not be able to bill (or be reimbursed) for claims with a date of service after the provider's termination date.
3. For primary care providers:
    a. Any patient who is currently assigned to this provider will be notified about their PCP terminating from the WellSense Provider Network.
    b. Notices will go out to each patient within 15 days of this notification.
    c. Panel will be re-assigned accordingly.

4. For specialist providers:
    a. Any patient who has seen this provider within the past 12 months will be notified about this specialist leaving the WellSense Provider Network.
    b. Notices will go out to each patient within 15 days of this notification

I understand that WellSense will take the above steps.

Signature of Acknowledgment: _____

I certify that I am authorized to submit this type of communication.

Submit via Email: ProviderProcessingCenter@wellsense.org

Submit via Fax: 617-897-0818