Notice of Change Form

This form is for existing Alliance Health network providers who need to submit a change for their records.

Change requests are not guaranteed for approval and may require additional supporting documentation and information, as well as possible changes to your contract.

Please ensure all applicable changes have been made or will be made in NCTracks. Final disposition will not be completed until all applicable changes are confirmed in NCTracks.

Please note that as a contractor with Alliance Health, you are required to notify Alliance **30 days** in advance of any business change.

Completed forms should be emailed to enrollment@AllianceHealthPlan.org.

Provider and requester information

1

Please indicate your entity type:*

○ Agency/Group ○ Licensed independent practitioner ○ Hospital system ○ Physical / allied health provider

Provider name (if applicable) _____

Tax ID* ☐☐-☐☐☐☐☐☐☐

SSN if no Tax ID* ☐☐☐-☐☐-☐☐☐☐

Provider Address Line 1* _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City* _____ State* _____ Postal code* _____

Phone* _____

Primary contact name:* _____ Title:* _____

Contact address (if different from provider address above)

Address line 1 _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City _____ State _____ Postal code _____

Phone* _____ Email* _____

Directions

Submit pages 1, 2, the appropriate section(s) checked below, and the signature page (page 6) prior to returning the form.

2

Action	Effective date (mm/dd/yyyy)	Section to be completed
☐ Name change	_____	Complete Section A
☐ Service site address change (unlicensed site reviews and/or HCBS reviews may be required)	_____	Complete Section B
☐ Phone # add/delete	_____	Complete Section B
☐ Remove a service location	_____	Complete Section C
☐ TCM voluntary termination	_____	Complete Section D
☐ Remove a service	_____	Complete Section D
☐ Change TIN	_____	Complete Section E
☐ Change main contact (name and number to be listed on provider directory)	_____	Complete Section F
☐ Change primary contact (contract)	_____	Complete Section F
☐ Change primary contact (claims)	_____	Complete Section F
☐ Contract withdrawal/termination	_____	Complete Section G
☐ Other	_____	Complete Section H

Section A - Name Change

If you are submitting a name change, you will also need to submit a new form W-9 with your completed form.

3

Current name: _____

New name: _____

Reason for name change: _____

Updated website: _____

Section B - Service site address and/or phone change

***30 DAY NOTICE IS REQURED**. If location changes are made provider is responsible for obtaining authorizations and ensure that billing practices will correspond to any change.

4

Site NPI number: ☐☐☐☐☐☐☐☐☐☐

NCTracks Location Code: ☐☐☐

End Date

Address line 1 _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City _____ State _____ Postal code _____

Phone _____ Fax _____

Email _____

Add

Address line 1 _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City _____ State _____ Postal code _____

Phone _____ Fax _____

Email _____

County _____

Contact person

Contact Name _____ Title _____

Phone _____ Email _____

Is the site handicap accessible? ○ Yes ○ No

If not what is the accessibility plan?

_____

Section C - Remove a service location

Note: The closure of a site and all services provided at the site is not an address change.

Arrangements for discharge/closure

You must also attach a document that fully explains the provider's plan, including:

- The rationale for the service removal
- The impact on members
- The discharge continuation of service plan
- The impact on staff
- A records management plan
- Your plan for addressing other obligations detailed in your network contract with Alliance Health

** This change requires a revision to your contract with Alliance Health and compliance with continuation of care guidelines.
30 DAY NOTICE IS REQUIRED.

5

Name of site: _____

Site NPI number: ☐☐☐☐☐☐☐☐☐☐

NCTracks Location Code: ☐☐☐

Address line 1 _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City _____ State _____ Postal code _____

Phone _____ Fax _____

County in which this site is located _____ Planned closing date (mm/dd/yyyy) _____

Contact person at site

Name _____

Phone _____ Email _____

Current number of members in service _____

List all services and corresponding codes that are being discontinued:

Section D - Remove a service

Arrangements for discharge/closure

You must also attach a document that fully explains the provider's plan, including:

- The rationale for the service removal
- The impact on members
- The discharge continuation of service plan
- The impact on staff
- A records management plan
- Your plan for addressing other obligations detailed in your network contract with Alliance Health

** This change requires a revision to your contract with Alliance Health and compliance with continuation of care guidelines. **30 DAY NOTICE IS REQUIRED**.

If you need to include more than 3 locations or additional services, please include them as additional documentation and attach the information with your submission.

6

Site NPI number: ☐☐☐☐☐☐☐☐☐☐

NCTracks Location Code: ☐☐☐

Address line 1 ______ Street, P.O. Box, etc. Address line 2 ______ Suite, Building, etc.

City ______ State ______ Postal code ______

Service(s) to be removed	Service(s) code

Current number of members in service ______ Requested effective date (mm/dd/yyyy) ______

Site NPI number: ☐☐☐☐☐☐☐☐☐☐

NCTracks Location Code: ☐☐☐

Address line 1 ______ Street, P.O. Box, etc. Address line 2 ______ Suite, Building, etc.

City ______ State ______ Postal code ______

Service(s) to be removed	Service(s) code

Current number of members in service ______ Requested effective date (mm/dd/yyyy) ______

Site NPI number: ☐☐☐☐☐☐☐☐☐☐

NCTracks Location Code: ☐☐☐

Address line 1 ______ Street, P.O. Box, etc. Address line 2 ______ Suite, Building, etc.

City ______ State ______ Postal code ______

Service(s) to be removed	Service(s) code

Current number of members in service ______ Requested effective date (mm/dd/yyyy) ______

Section E - Change tax identification number (TIN)

Tax ID change requests are not guaranteed for approval.

Name and Tax ID changes will require completion of a new application.

All name and tax ID changes will also require you to complete and submit the following IRS documents to this application:

- A copy of your W-9
- A complete SS4 OR 147C form

7

Provider name _____

Address line 1 _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City _____ State _____ Postal code _____

Phone _____ Fax _____

County _____

Delete tax ID ☐☐-☐☐☐☐☐☐☐

Add tax ID ☐☐-☐☐☐☐☐☐☐

Reason for changing TIN:

Section F - Change of contact

Use this section to request changes to the main contact for the provider directory or primary contact for contracts, claims or **QM**.

8

Delete this contact person _____

Add this contact person _____

Phone _____ Fax _____

Email _____ Title _____

This contact is

☐ Main contact for Provider Directory ☐ Primary contact for contracts

☐ Primary contact for billing/claims ☐ Primary Contact for Quality Management (QM)

Section G - Contract withdrawal

Request to voluntarily withdraw contract

***Removal of ALL services and sites: minimum **30-day notice is required.**

***You will be contacted by a member of the network team for follow-up.
***Adequate notice to members and Alliance is REQUIRED per your contract with Alliance.

9

Closing effective date (mm/dd/yyyy): _____

Contact person for member transition plan: _____

Phone: _____ Email: _____

Primary contact person requesting contract withdrawal (CEO, owner, director, etc): _____

Phone: _____ Email: _____

Rationale for change:

Section H - Other

10 Describe any other changes/comments you wish to make which have not been addressed in the other sections of this form.:

Authorization

11

Full name* _____ Title* _____

Phone* _____ Email* _____

Signature (name or typed)* Date (mm/dd/yyyy)*

x		

Submission instructions

Submit completed form and supporting documentation (as necessary) to enrollment@AllianceHealthPlan.org.