SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.548.1224 | 715.221.8000
TTY: 711

Provider/Practice Change Notification

Affiliated practices should use this form to notify Security Health Plan of changes, additions or terminations for affiliated providers or changes within your practice location(s). To add a provider to an existing contract, Security Health Plan credentialing staff will contact you to begin the credentialing process. SHP will not reimburse for services provided prior to approval of a provider's credentialing.

If your practice is not currently affiliated with Security Health Plan, but wishes to begin the affiliation process, please submit a completed Provider/Practice Affiliation Request form. This form can be found on our website www.securityhealth.org by selecting Provider Document Library under the Providers section.

Return your completed Provider/Practice Change Notification via email, fax or mail to:

Email: shpprd@securityhealth.org

Fax: 715.221.9699

Security Health Plan
Provider Relations and Contracting
PO Box 8000
Marshfield, WI 54449-8000

Requester name/title		Email address
Practice name		
Phone number	Fax number	Date form completed

Reason for update:

☐ Practitioner change (complete Section 1)
☐ Practice change (complete Section 2)

Section 1 – Practitioner change

Last name	First name	Birthdate (m/d/y)	NPI

Reason for update(s):

☐ New practitioner – SHP credentialing staff will contact you for credentialing

☐ Term practitioner (check appropriate box): Effective date (m/d/y) _____ /_____ /_____

☐ Deceased ☐ Retired ☐ Moving outside the service area

☐ Transferring to another SHP affiliated practice: ☐ Yes ☐ No

If yes, what practice is provider transferring to ______________________________

Are patients staying at current practice: ☐ Yes ☐ No

☐ Other ______________________________

☐ Name change: Effective date (m/d/y) _____ /_____ /_____

From ______________________________ To ______________________________

☐ Licensure change: Effective date (m/d/y) _____ /_____ /_____

New profession ____________________ New license # ____________________ License state ______

 © 2004 – 2016 Security Health Plan of Wisconsin, Inc.

Section 1 – Practitioner change (continued)

☐ Service location change (if needed, add additional sheets):

Location name		☐ Add ☐ Remove	Effective date
Address			
City		State	ZIP code
Phone number	Facility NPI for this site	Primary site: ☐ Yes ☐ No	Print in directory: ☐ Yes ☐ No
Provider's specialty at this site			

Section 2 – Practice change

Reason for update(s):

☐ ***Additional location for currently affiliated practice*** (To add a new satellite location for an existing practice, submit a completed Practice Information form. This form can be found on our web site www.securityhealth.org by selecting Provider Document Library under the Providers section.)

☐ ***Terminate a practice*** (check appropriate box): Effective date (m/d/y) _____ /_____ /_____

☐ Reimbursement rates ☐ SHP business decision ☐ Practice decision

☐ Practice purchased ☐ Practice closed ☐ Practice disaffiliated

☐ Other ____

Practice name			
Tax ID	NPI	Termination date	
Address			
City		State	ZIP code

☐ ***Practice name/tax ID/NPI change*** (a W-9 must be included for a tax ID change):

Current practice name			
Tax ID	NPI		
Address			
City		State	ZIP code
New legal name			
New tax ID	New NPI	Effective date	
New billing address			
City		State	ZIP code
New mailing address (if different than billing address)			
City		State	ZIP code
New tax ID	New fax number	Medicare number	Medicaid number
Office manager name	Office manager email address		

SHP USE ONLY: Contract managers/Provider Relations staff should submit this form for changes via Operations Task Tracking System Request.

 © 2004 – 2016 Security Health Plan of Wisconsin, Inc.