



Minnesota Health Care Programs (MHCP)

Individual Practitioner - MHCP Provider Profile Change Form

As a Minnesota Health Care Programs (MHCP) provider, you must keep MHCP Provider Enrollment informed of your most up-to-date information. Use this form to notify MHCP of the following (check all that apply):

- Name change, Office location address change, Alternate mailing address(es) change, Add or terminate group affiliations, Add my private practice, Terminate enrollment with MHCP

INDIVIDUAL PRACTITIONER PERSONAL PROFILE - all information required

Form with fields: NPI/UMPI, SOCIAL SECURITY NUMBER, DATE OF BIRTH, LAST NAME, FIRST NAME, MIDDLE NAME, PREVIOUS NAME (if applicable), INDIVIDUAL PRACTITIONER'S E-MAIL (if applicable)

TERMINATE MY ENROLLMENT PARTICIPATION WITH MHCP

Effective Date ___/___/___

If you terminate your MHCP enrollment, you will no longer receive MHCP payment for services after the date you indicate below.

Form with fields: FORWARDING ADDRESS, CITY, STATE, ZIP CODE, PROVIDER SIGNATURE (Required), DATE

INDIVIDUAL PRACTITIONER'S LICENSES/CERTIFICATIONS

List below and enclose a copy of each current license and certification. (Required)

Table with 5 columns: License/Certification Number, Original Issue Date, End Date, Type of License/Certification, Issuing State

INDIVIDUAL PRACTITIONER'S SPECIALTY

List up to six specialties if applicable.

Table with 6 empty columns for listing specialties

PRIVATE PRACTICE OR PRIMARY OFFICE LOCATION INFORMATION Effective Date ___/___/___

You must check **both** boxes below.

Do you maintain your own private practice? Yes No

Are you employed and/or independently contracted by a group practice? Yes No

If you maintain your own private practice, this must be listed as your primary office location. List your **private practice** information below. If you **do not** maintain a private practice, list your primary office location below. If you have a group NPI for your private practice, complete a [Provider Enrollment Application and Provider Agreement](#) for the practice.

PRACTICE NAME (if applicable)		GROUP NPI/UMPI (if applicable)	
LOCATION ADDRESS (Practice location cannot be a PO Box)			
CITY	STATE	ZIP CODE	COUNTY
OFFICE PHONE NUMBER ()		OFFICE FAX NUMBER ()	
FEDERAL TAX ID NUMBER (if applicable)		LEGAL NAME ACCORDING TO THE IRS (Do not abbreviate)	
MINNESOTA TAX ID (if applicable)		FISCAL YEAR END (default is 12/31) ___/___/___	

ALTERNATE MAILING ADDRESSES Effective Date ___/___/___

You can receive various types of information (listed below) at one of three addresses. Your office location is Address 1 (above). If you want to receive information at an alternate address, list up to 2 more addresses below.

Do not list additional **practice** location addresses here. See Group Affiliation Information of this form to list additional affiliation locations.

Address 2			Address 3		
ATTN			ATTN		
ADDRESS			ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE

Send my:

- Remittance Advice
- Reimbursement Check
- Provider Correspondence
- Authorization Request Notice and Service Agreements
- Credentials (Enrollment Status)
- 1099 IRS Form

Enter only one digit: 1, 2 or 3 in each box

- to address:

GROUP AFFILIATION INFORMATION

List **all** group affiliations billing MHCP services for you. You must include sites that continue to bill services for you. Any sites on your profile not listed will be removed. If you need more space, copy this page as needed and attach to this form. List only the requested information.

GROUP NAME	GROUP NPI/UMPI
PRACTICE LOCATION ADDRESS	
<input type="checkbox"/> Continuing <input type="checkbox"/> Add new site <input type="checkbox"/> Remove site	EFFECTIVE DATE __/__/__

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PRACTICE LOCATION ADDRESS	
<input type="checkbox"/> Continuing <input type="checkbox"/> Add new site <input type="checkbox"/> Remove site	EFFECTIVE DATE __/__/__

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GROUP NAME	GROUP NPI/UMPI
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