Parkland Community Health Plan, Inc.
Provider Action Form

Action *Please check (3) one or more as appropriate*	**Effective Date**
☐ Add Provider ☐ Delete Provider ☐ Address/Phone Change ☐ Additional Information ☐ Tax ID /Medicaid/TPI # Change ☐ Other *(please explain)*:	

Provider Information

Last Name	**First Name**	**MI**	**Degree**

Provider NPI #	**DOB**	**SSN**

Group NPI #	**Provider Specialty**	**Category**

License #	**Tax ID #**	**Medicaid/TPI #**

Street Address			
City	**State**	**Zip Code**	**County**

Phone	**Fax**	**Pager**

Additional Locations

(please use additional sheets if needed)

Billing Name Information			
Street Address			
City	**State**	**Zip Code**	**County**

Phone	**Fax**	**Pager**

Practice Name/Health Center Name			**Medicaid/TPI #**
Street Address			
City	**State**	**Zip Code**	**County**

Phone	**Fax**	**Pager**

Additional Comments

Requestor Name	**Requestor Signature**	**Date**	**Phone**

Please submit to **PCHPProviderInfoUpdate@phhs.org**