



Provider Update Form

Requestor's name: _____ Requestor's phone: _____

Provider/group name: _____ Provider/group NPI: _____

Today's date: _____ Effective date: _____

Please note notification requirements listed below.

Name change *Current information:* _____ *New information:* _____

Tax ID _____ _____
(W-9 form required)

Practice address Street _____
City, State, ZIP _____
Phone: _____ Fax: _____

Billing address Street: _____
(W-9 form required) City, state, ZIP: _____
Phone: _____ Fax: _____

Panel status
 Open
 Closed (30-day notice required)
 Limited (30-day notice required)
Restrictions: _____
 Change to concierge medicine (90-day notice required)

Health Care Option (HCO)
(HCAS form and joinder [if applicable] required)
Current information: *New information:*
 Change: _____
 Additional: _____

Termination from FCHP
(60-day notice required)
Reason: _____

Other
Please specify: _____

Please return completed form to FCHP via:

Mail: Fallon Community Health Plan, Attn: Provider Relations, 10 Chestnut St., Worcester, MA 01608
Fax: 1-508-368-9902

For mental health and/or substance abuse provider updates, please contact Beacon Health Strategies at 1-888-421-8861.
For general dentistry provider updates, please contact Dental Benefit Providers at 1-888-638-0048.
For chiropractor provider updates, please contact American Specialty Health at 1-800-848-3555.