Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

PROVIDER INFORMATION UPDATE FORM

Use this form to register and/or update your provider information (e.g., service location(s), payment address, tax identification number, etc.) with Gold Coast Health Plan (GCHP). Please complete all applicable sections. Providing complete and legible information will expedite your request and help ensure accurate processing. The completed form should be returned by email to ProviderRelations@goldchp.org ATTN: Provider Relations Department.

☐ New Provider ☐ Existing Provider

Section 1: Group / Facility Information

Group / Facility Name:		Tax ID Number:
Group / Facility's Web URL Address:		Corporate NPI:
Office Contact Name:	Contact Telephone Number:	*Contact Email Address:

Section 2: Professional Information

Professional's First Name:	Professional's Last Name:	Title / Type of Licensure (i.e., MD, DO):
Professional NPI:	CAQH Provider ID:	Date of Birth:
Supervising Physician's Individual NPI (applies only to Physician Extenders):	Medical License Number:	Total Capacity (Maximum 2,000): (Applies only to PCPs)
☐ PCP ☐ Specialist ☐ Physician Extender (i.e. NP, PA) ☐ Hospital-Based Professional (Only chose one)	Primary Specialty Type: Board Certified (Y/N): Taxonomy Code:	Secondary Specialty Type: Board Certified (Y/N): Taxonomy Code:
Patient Age Limits: From To (If under 18 years old, indicate 17.99)	Sees Children: ☐ Sees only children under 18 ☐ Sees children under 18 AND adults (18 and over) ☐ Sees only adults (18 and over)	Patient Gender Limits: ☐ Male ☐ Female ☐ Both

* Legal documentation is required for changes to last name (e.g., marriage license).
* Only primary specialty will be listed in provider directory.
* Please provide your current email address to receive GCHP Memos, Provider Operation Bulletins, and/or other essential alerts from the Plan.

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NOTE: FOR SECTIONS 3-8, COMPLETE ONLY THE SECTION(S) THAT REQUIRES A CHANGE.

Section 3: Languages Spoken

List non-English languages spoken by the provider and/or staff in order of fluency. Check 'P' for Provider and 'S' for Staff.

1 _____ P ☐ S ☐ 2 _____ P ☐ S ☐ 3 _____ P ☐ S ☐

Section 4: Service Location

Please complete a separate form for each additional location or attach a company roster that includes the requested information below.

☐ Add new location ☐ Terminated ☐ Correction to existing location

☐ Office location ☐ Other (independent diagnostic center, supplier, etc.): _____

SERVICE LOCATIONS, TIME ALLOCATION AND PERCENTAGE OF TIME

If more than two locations, please complete a separate form for each additional location or attach a company roster that includes the requested information below.

Location ☐ Exclude from Provider Directory			Location ☐ Exclude from Provider Directory		
Location Name (if different than Group Association Name above):			Location Name (if different than Group Association Name above):		
Accepting New GCHP Medi-Cal Members: ☐ Yes ☐ No ☐ Existing Patients Only			Accepting New GCHP Medi-Cal Members: ☐ Yes ☐ No ☐ Existing Patients Only		
Percentage of Time Allocated to GCHP Member: %			Percentage of Time Allocated to GCHP Member: %		
Street Address:			Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Is This Your Primary Location? (Y/N):			Is This Your Primary Location? (Y/N):		
Telephone Number:	Fax Number:		Telephone Number:	Fax Number:	
Email Address (if different than Section 1):			Email Address (if different than Section 1):		
Clinic / Location NPI (if different than Corporate NPI):			Clinic / Location NPI (if different than Corporate NPI):		

Location Office Hours							
	M	T	W	Th	F	Sat	Sun
A.M.							
P.M.							
Percentage of Time Spent at this Clinic: %							
Total No. of Medi-Cal / GCHP members provider will accept at this location: (If multiple locations, please enter unique number for this location).							

Location Office Hours							
	M	T	W	Th	F	Sat	Sun
A.M.							
P.M.							
Percentage of Time Spent at this Clinic: %							
Total No. of Medi-Cal / GCHP members provider will accept at this location: (If multiple locations, please enter unique number for this location).							

Section 5: Payment / Billing Address

☐ Check box if billing address is the same as the service address.

A signature at the bottom of this form by the Tax ID owner is required for all payment address changes.

Current Address		
Provider Name (last, first, middle initial / business name):		
Street Address:		
City:	State:	Zip:
Telephone Number:	Fax Number:	
Email Address:		

Former Address (Changes only)		
Provider Name (last, first, middle initial / business name):		
Street Address:		
City:	State:	Zip:
Telephone Number:	Fax Number:	
Email Address:		

Section 6: Mailing Address

☐ Check box if mailing address is the same as the service address.

Current Address		
Provider Name (last, first, middle initial / business name):		
Street Address:		
City:	State:	Zip:
Telephone Number:	Fax Number:	
Email Address:		

Former Address (Changes only)		
Provider Name (last, first, middle initial / business name):		
Street Address:		
City:	State:	Zip:
Telephone Number:	Fax Number:	
Email Address:		

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Section 7: Tax Identification Number / Employer Identification Number (TIN / EIN)

If joining a participating group, please use the group's TIN to associate the request with the participating group.
In order to update your Tax ID number, a completed W-9 must be attached to this form.

Current TIN / EIN:	Former TIN / EIN (change only):	Effective Date of TIN Change:

Section 8: Hospital Affiliation Update

A hospital privilege letter from the facility along with written notification from the provider's office (administrator, manager, provider, etc.) and/or attestation form for hospital-based physicians is required.

** If no hospital privileges, please provide a letter or copy of an agreement with a provider that will admit for you.

Hospital Name	Add / Delete?	Effective / Expiration Date
(1)	Add ☐ Delete ☐	
(2)	Add ☐ Delete ☐	

Comments (Please Summarize Request):
Effective Date of Request (MM / DD / YY):

Print Name of
Physician / Provider: _____

Signature of
Physician / Provider: _____ Date: _____