Santa Clara Family Health Plan™

Change Notification Form

Provider Services

Phone: **1-408-874-1788**
Fax: **1-408-362-9817**
Email: ProviderServices@scfhp.com

To	Provider Services Database Administrator	**Fax**	1-408-362-9817 or email to ProviderServices@scfhp.com
From		**Date**	

Please fill out the form below to notify Santa Clara Family Health Plan of any changes to your demographic information. You are required to notify SCFHP immediately regarding any changes to this information. If you wish to make changes in your participation status or have any questions, please call our Provider Services Department at **1-408-874-1788**.

Provider Name (Required)			
License # (Required)		**Accepting New Patients**	☐ Yes ■ No
Address			
Phone		**Fax**	
Email		**Website**	
Office Hours			
Specialty			Board Certified ☐ Yes ■ No
			Board Certified ☐ Yes ■ No
Hospital Privileges			

IPA/Provider Group/Medical Group	
Languages Spoken by Provider	
Languages Spoken by Office Staff (Non-Clinical)	
Languages Spoken by Clinical Staff	
Languages Spoken by Skilled Medical Interpreters at this Location	

Current Tax ID #		**New Tax ID #***		**Effective Date**	

*If submitting a new tax ID number, please complete a W-9 form.