



Provider Update Form



NOTE: This is not a credentialing application. We will use the information provided on this form to determine credentialing requirements. If credentialing is required, you will be contacted by our Credentialing staff, or you may provide the practitioner's CAQH ID below and we will obtain required credentialing documents from CAQH ProView.

****If you are submitting an update for WEA Trust & Health Tradition, please only submit one form****

Return your completed update form via e-mail, fax, or mail to:

WEA Trust
P.O. Box 21538
Eagan, MN 55121
Telephone: (800) 279-4090
Fax: (608) 276-9119
E-mail: providerupdates@neugenhealth.com

Health Tradition Health Plan
P.O. Box 21171
Eagan, MN 55121
Telephone: (877) 832-1823
Fax: (608) 781-9654
E-mail: providerupdates@neugenhealth.com

Section 1: Organization/Business Practice and Contact Information

Organization/Business Legal Name (as filed with WEA Trust and/or Health Tradition):		Tax ID #:	
Form Submitted by (name/title):			
Phone Number (with area code):		Fax Number (with area code):	
E-mail:		Date Submitted:	

Reason(s) for update: Place an "X" next to all that apply. Provide additional information in following sections.

<input type="checkbox"/> Legal name change (Complete Section 2)	<input type="checkbox"/> Practitioner change(s) (Complete Sections 3 and 4)
<input type="checkbox"/> Federal tax ID # change (Complete Section 2)	<input type="checkbox"/> Service location change(s) (Complete Section 4)
<input type="checkbox"/> Billing/mailling contact change (Complete Section 2)	<input type="checkbox"/> Practice closed Effective Date: _____

Section 2: Organization/Practice Information Updates

New Legal Name (as indicated on W-9):		New Tax ID #:		Effective Date:	
New Remittance Address:					Effective Date:
Organization (Type 2) NPI	New Billing Phone Number (with Area Code):	New Billing Fax Number (with Area Code):		Effective Date:	
New Mailing Address:					Effective Date:

NOTE: Attach a current W-9 for all legal name and federal tax ID changes. Attach forwarding information for practice closures.

Section 3: Practitioner Updates

Please make copies of this page as needed to document all practitioner changes.

Last Name:		First Name:		MI:
Credentials:		Date of Birth:	<input type="checkbox"/> Female <input type="checkbox"/> Male	
Individual's NPI #:	CAQH ID:	License Number(s):		
Practicing Specialty (Primary first, followed by all additional specialties):				
PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		Hospitalist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Locum Tenens? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list dates of coverage:	Start Date:	End Date:	
Languages Spoken (other than English):	Cultural Background:	Cultural Competency Training:	Ethnicity:	

Reason(s) for update: *Indicate all that apply*

Practitioner added to staff - *List service locations in Section 4* Effective Date: _____

Practitioner leaving staff Effective Date: _____

Reason: Leave of absence Expected Date of Return: _____

Practitioner retired

Practitioner deceased

Practitioner relocated New location: _____

Other Please explain: _____

Practitioner demographic data change(s) (*indicate all that apply*) Effective Date: _____

Name

Specialty

Credentials Please explain: _____

Licensure Please explain: _____

Service location change(s) – *List in Section 4*

Section 4: Service Location Updates

Please make copies of this page as needed to document all service location changes.

Location Name:		<input type="checkbox"/> Add <input type="checkbox"/> Remove	Effective Date:
Address:			
City:		State:	ZIP:
Phone Number (with area code):	Facility NPI for this site:	Primary Site? <input type="checkbox"/> Yes <input type="checkbox"/> No	Directory Suppress? <input type="checkbox"/> Yes <input type="checkbox"/> No
Practicing Specialty at this Site:			Telemedicine? <input type="checkbox"/> Yes <input type="checkbox"/> No

Location Name:		<input type="checkbox"/> Add <input type="checkbox"/> Remove	Effective Date:
Address:			
City:		State:	ZIP:
Phone Number (with area code):	Facility NPI for this site:	Primary Site? <input type="checkbox"/> Yes <input type="checkbox"/> No	Directory Suppress? <input type="checkbox"/> Yes <input type="checkbox"/> No
Practicing Specialty at this Site:			Telemedicine? <input type="checkbox"/> Yes <input type="checkbox"/> No