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 WEA Trust Credentialing staff, or you may provide the practitioner's CAQH ID below and we will obtain required credentialing documents from CAQH ProView.

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

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

Section 1: Organization/Business Practice and Contact Information

Organization/Business Legal Name (as filed with WEA Trust):	Tax ID # (as filed with WEA Trust):

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.*

- ☐ Legal name change **(Complete Section 2)**
- ☐ Federal tax ID # change **(Complete Section 2)**
- ☐ Billing/mailing contact change **(Complete Section 2)**
- ☐ Practitioner change(s) **(Complete Sections 3 and 4)**
- ☐ Service location change(s) **(Complete Section 4)**
- ☐ 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:	☐ Female ☐ Male

Individual's NPI #:	CAQH ID:	License Number(s):

Practicing Specialty (Primary first, followed by all additional specialties):

PCP? ☐ Yes ☐ No	If yes, accepting new patients? ☐ Yes ☐ No	Hospitalist? ☐ Yes ☐ No

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:	☐ Add ☐ Remove	Effective Date:
Address:		
City:	State:	ZIP:

Phone Number (with area code):	Facility NPI for this site:	Primary Site? ☐ Yes ☐ No	Directory Suppress? ☐ Yes ☐ No

Practicing Specialty at this Site:

Location Name:	☐ Add ☐ Remove	Effective Date:
Address:		
City:	State:	ZIP:

Phone Number (with area code):	Facility NPI for this site:	Primary Site? ☐ Yes ☐ No	Directory Suppress? ☐ Yes ☐ No

Practicing Specialty at this Site: