# RCM Provider Change Form

**RCM Client ID:**

*Please note this is a two page form. Return information is listed on the bottom of page 2.*

| *REQUEST TYPE (select all that apply): | |
|---|---|
| **New Sub-Office**<br>**Adding to an Existing Office**<br>**Remove an Existing Office**<br>**Remove Providers from Existing Office** | **Do you want to Test? YES NO**<br>If Yes, we will send you a secure email to attach your file to. |
| **Professional Claims**<br>**Institutional Claims** | |

| *Contact Name | *Phone Number | Ext. |
|---|---|---|
| | | |

| *Email Address | Fax |
|---|---|
| | |

| *Provider / Practice Name | * Tax ID | * NPI | *State |
|---|---|---|---|
| | | | |

| Special Notes (i.e. ERA naming convention, etc.) |
|---|
| |

*If you are adding a new Practice, EDI enrollment may be required for claims and/or ERAs. Please see the* ***HeW Payer List****. The Paperwork Submission section on each instruction sheet provides information on what forms should be sent directly by you to the payers.*

*If you are completing ERA paperwork, please fill out the table below to ensure delivery of those ERAs once the payer starts to make them available to Availity. Payer ID is required.*

| Name of Payer | Payer ID | Name of Payer | Payer ID |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Helpful Hints for Page 2:**

- Office Name = Corp Office Name in RCM
- Client Customer Number = RCM ID
- New Name/Address/Tax ID Information – Only complete if you are changing your Corp Office Name with Availity.
- Standard Service Fee – for Internal Use ONLY
- **Please note: Signature is required to process forms. Unsigned forms will be returned.**

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**Provider Change Form**

## Current Name & Client Customer Number / Address / Tax ID Information

**Office Name** : **Client Customer Number** :

| Street Address: | | |
|---|---|---|
| City: | State: | Zip: |
| Phone: | Fax: | Tax ID: |
| Email: | | |

## New Name/Address/Tax ID Information

| Office Name ("Subscriber"): | | |
|---|---|---|
| *Street Address:* | | |
| City: | State: | Zip: |
| Phone: | Fax: | Email: |
| Contact Name: | | Effective Date of Change: |

**Tax ID #:**

## ADD PROVIDER(S)/Office

| Provider Name | Billing NPI, Rendering NPI, and Tax ID | Effective Date |
|---|---|---|
| | | |
| | | |
| | | |

## DELETE PROVIDER(S)

| Provider Name | Billing NPI, Rendering NPI, and Tax ID | Effective Date |
|---|---|---|
| | | |
| | | |
| | | |

## Standard Service Fees *(Internal Use ONLY)*

**Standard Fees:** per licensed provider per month * **Current Monthly Fee:**
**New Monthly Subscription Fee:**
***Effective Date for New Monthly Subscription Fee:** **Upon Receipt** **Setup Fees (if applicable):** **Waived**
* The foregoing fee is based on at least 75% of claim volume delivered electronically through Availity RCM and 25% or less of all claims forced to paper by payer requirements. For paper claim volume greater than 25%, Drop-to-Paper service fees will apply: $0.43 for the first page of each claim, $0.10 per additional page and forwarding service fee of $0.35 per automatically forwarded claim.

## Signature

This Provider Change Form between the Subscriber and Availity RCM Corporation ("Availity RCM") authorizes the above referenced changes. Please Note: THIS IS NOT A CANCELLATION FORM.

| **AVAILITY RCM CORPORATION** | | **Subscriber**: | |
|---|---|---|---|
| Signature: | | Signature: | |
| Print Name: | Scott E. Herbst | Print Name: | |
| Title: | Sr. V.P., General Counsel and C.A.O. | Title: | |
| Date: | | Date: | |

**Once signed and completed please FAX back to 406-449-0190 or email to h2rproviderchangerequest@availity.com**