

F. Change Information for an Individual Practitioner within your organization:

Practitioner Name: _____	Title: _____
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Change in Employment Status or Location within your organization: (check one)

<input type="checkbox"/> Retired – Effective Date: _____	<input type="checkbox"/> Termed Employment/Resigned – Effective Date: _____
<input type="checkbox"/> Moved or Added Additional Site(s) – Effective Date: _____	
Check the Appropriate Box below for Moving an individual Provider and Complete ALL Applicable Information.	
<input type="checkbox"/> The Provider has moved from one site to another within your organization Remove Provider from Directory Listing at this location: _____ Add Provider to Directory Listing(s) at this location: _____	
<input type="checkbox"/> The Provider is rendering services at an additional location(s) within your organization List locations within the directory to include this provider: _____	

Change Languages Spoken by Practitioner: Please use this section to make any language corrections necessary for the directory

<input type="checkbox"/> Add: _____	<input type="checkbox"/> Delete: _____
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Change Practitioner Name: Please use this section to make any spelling corrections necessary for the directory

Current Spelling: _____	Correct Spelling: _____
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Plan Notification: Per your agreement, the Plan must be notified in writing of any significant changes in the **availability or location** of covered services, or any significant change in information. (e.g. change of address, phone number, or office hours)

Was Gold Kidney notified of the change(s) represented on this form?

Yes - Please attach a copy of the notification **No**

How were members notified? Choose one

Mailed Letters to Gold Kidney

Explanation of Changes listed above:**Information Verification**

I hereby affirm that the information submitted in this application is correct and complete to the best of my knowledge and belief, and is furnished in good faith.

Please process the changes listed above with the effective date of _____

Printed Name of Person Completing Form: _____ Date: _____

Signature: _____ Title: _____

Contact Email: _____ Contact Phone: _____

Return this form to the Provider Relations Department as directed below:

Return this by fax to 1 (866) 580-0122 Or email to providerrelations@goldkidney.com