



Provider Change Request Form

Complete the applicable section(s) of this form to request a change to your information with Vaya Health (Vaya).

This minimal information will allow Vaya to retrieve your provider data details from the Provider Enrollment File (PEF), which is maintained by the NC Department of Health and Human Services (NCDHHS).

Date of request: _____

Network type: Behavioral health, intellectual/developmental disabilities (I/DD), and/or traumatic brain injury (TBI)
 Physical health

Provider Information

1. Provider type:

- Organization, e.g., physician group, agency, ancillary, clinic, or a freestanding non-hospital facility such as a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), lab, durable medical equipment (DME) provider, home health provider, etc.
- Licensed independent practitioner (LIP) or sole proprietor
- Hospital

2. Legal name of provider: _____

3. Federal tax ID No. or Social Security No.: _____ Provider's NPI No.: _____

Contact Information

Primary contact name: _____

Phone: _____ Email: _____

Submit this completed, signed request form to:

Vaya Health
Attn: Provider Enrollment Services
200 Ridgefield Court, Suite 218
Asheville, NC 28806

OR ProviderEnrollment@vayahealth.com

Document Checklist

Check the Change(s) Requested Below:	Section to Complete
<input type="checkbox"/> Remove site(s)/address	Section A
<input type="checkbox"/> Remove service(s)	Section B
<input type="checkbox"/> Add/remove a enrolled practitioner	Section C
<input type="checkbox"/> Change NPI number	Section D
<input type="checkbox"/> Change taxonomy code	Section D
<input type="checkbox"/> Other change(s)	Section E

Signature and Attestation

By signing below, I hereby acknowledge, agree, and certify that all of the information and attachments provided herein are true and accurate to the best of my knowledge. I further understand that any false or misleading information may cause for denial, suspension, or termination of any and all agreements with Vaya Health (Vaya). Submission of this request does not guarantee approval of the same.

I further acknowledge, agree, and signify my willingness for Vaya to verify any and all information presented in this request. I agree to submit any additional information upon request to verify the accuracy and truthfulness of the information contained herein or submitted herewith and to address any issues that may arise during the processing of this request. I hereby give my consent for Vaya to interview or gather additional information from any individuals who may have information related to the requests herein. Finally, I attest that I am not aware of any conflict of interest existing between Vaya and the requesting provider or me.

If I am changing the name, federal or state tax identification number, and/or entity type of a Vaya-contracted organization, licensed independent practitioner, or hospital, by signing below I expressly acknowledge, agree, and certify that the organization, licensed independent practitioner, or hospital (as applicable) that exists after the change to name, tax identification, and/or entity type in whatever form, agrees without objection the terms and conditions of any and all agreements, including, but not limited to, and only by way of example, contracts, purchase orders, memoranda of understanding, memoranda of agreement, and/or maintenance of effort agreements, entered into and in existence by, between and among Vaya and provider immediately prior to the approval of the request(s) herein.

Provider name (print)

Date

Signature of Legally Authorized Representative

Title of Legally Authorized Representative (print)

Section A: Change or Remove Site(s)/Address

Requested effective date: _____

Request is to: Change site(s)/address Remove site(s)/address

Request for: Organization LIP or sole proprietor Hospital

New Address (Used for change of address only):

Street address or P.O. Box: _____ County: _____

City: _____ State: _____ ZIP+4: _____

Site/facility name: _____ Site NPI No.: _____

Address to be removed/changed:

Street address or P.O. Box: _____ County: _____

City: _____ State: _____ ZIP+4: _____

Site/facility name: _____ Site NPI No.: _____

Why are you requesting Vaya remove this site from your contract?

Do licensed practitioners bill for services provided at this location? Yes No

(If yes, attach a list of practitioners and NPI numbers.)

Have services been delivered to Vaya members/recipients from this site within the last 90 days? Yes No

If yes, please note that this change may require arrangements for discharge/closure and/or proper notice to members/recipients and Vaya, as detailed in your contract. Attach a narrative that fully explains the following:

- *Rationale for the removal of this site*
- *Number of Vaya members/recipients currently receiving services that are billed through this site*
- *Impact on Vaya members/recipients and the plan for discharge/continuation of services*
- *Impact on provider staff/number of staff affected*
- *Records management plan*
- *Plan for meeting all other applicable requirements of your network contract with Vaya*

Note: For questions regarding discharge planning/notice requirements, contact your assigned provider network contract manager. If you do not have an assigned provider network contract manager, email provider.info@vayahealth.com.

Section B: Remove Service(s)

Requested effective date: _____

Physical site address:

Street address or P.O. Box _____ County _____

City _____ State _____ ZIP+4 _____

Site/facility name: _____ Site NPI No.: _____

Provide the following information for all services to be removed:

Service Description	Service Code	NPI #	Taxonomy #	Medicaid/ State Funding

Why are you requesting Vaya remove this service from your contract?

Are there licensed practitioners at this location? Yes No

(If yes, attach a list of practitioners and NPI numbers.)

Have services been delivered to Vaya members/recipients from this site within the last 90 days? Yes No

If yes, please note that this change may require arrangements for discharge/closure and/or proper notice to members/recipients and Vaya, as detailed in your contract. Attach a narrative that fully explains the following:

- Rationale for the removal of this site
- Number of Vaya members/recipients currently receiving services that are billed through this site
- Impact on Vaya members/recipients and the plan for discharge/continuation of services
- Impact on provider staff/number of staff affected
- Records management plan
- Plan for meeting all other applicable requirements of your network contract with Vaya

Note: For questions regarding discharge planning/notice requirements, contact your assigned provider network contract manager. If you do not have an assigned provider network contract manager, email provider.info@vayahealth.com.

Section C: Add/Remove an Enrolled Practitioner

Requested effective date: _____

Type of change (Check all that apply):

- ADD** an enrolled practitioner to your organization.
- REMOVE** an enrolled practitioner from your organization.
- REMOVE** an enrolled practitioner from a previous organization. *(Practitioner must sign below)*
- REMOVE** an enrolled practitioner from the Vaya network. *(Practitioner must sign below)*

Reason for request:

Add/Remove Practitioner:

Provide the following when adding a practitioner to your organization or individual practice:

Organization name: _____ Site NPI: _____

Site address:

Street address or P.O. Box: _____

City: _____ State: _____ ZIP+4 (required): _____

Attach a separate sheet to list all additional sites, if applicable, including each site's name, address, and NPI.

Practitioner name: _____ Date of birth: _____

Practitioner NPI No.: _____ Taxonomy code: _____

Phone: _____ Email: _____

License type: _____ Issue date: _____

Remove Practitioner from Previous Organization:

Name of organization practitioner is leaving: _____

Last date of employment: _____

Prior organization's contact person: _____ Contact number: _____

Practitioner's printed name:

Signature:

Date:

Section D: Change NPI No. or Taxonomy Code

Change NPI Number: *(Attach a copy of the taxonomy code and NCTracks documentation.)*

Requested effective date: _____

Type of change: Add NPI Revise NPI (NPI correction) Remove NPI

This NPI is for a/an: Organization LIP or sole proprietor Hospital

NPI number: _____ Name of individual or organization: _____

Site address:

Street address or P.O. Box: _____ County: _____

City: _____ State: _____ ZIP+4: _____

Reason for change:

Note: *A change to a NPI number will not take effect until the change is applied and reflected in NCTracks.*

Change Taxonomy Code: *(Attach a copy of the taxonomy code and NCTracks documentation.)*

Requested effective date: _____

Type of change: Add taxonomy Revise taxonomy (taxonomy correction) Remove taxonomy

This NPI is for: Organization LIP or sole proprietor Hospital

Taxonomy code: _____ Name of individual or organization: _____

This taxonomy is associated w/ NPI no.: _____

Site address:

Street address or P.O. Box: _____ County: _____

City: _____ State: _____ ZIP+4: _____

Reason for change:

Note: *A change to a taxonomy code will not take effect until the change is applied and reflected in NCTracks.*

