COMMUNITY CARE PHYSICIAN NETWORK

Practice/Clinician Change Form

Practice Information

Any change in demographics or provider participation must be reported to CCPN immediately as required in the CCPN Participation Agreement. Failure to do so could impact your participation in Prepaid Health Plans, Medicare Advantage, and other commercial plans.
Please check the appropriate box if any of the following have changed:

☐ Practice Name: _____

☐ Address: _____

Street Address _____ Suite # _____

City _____ State _____ Zip Code +4 _____ County _____

☐ Group NPI: _____ ☐ Primary Contact: _____

☐ Phone: _____ ☐ Email Address: _____

Providers to Remove

List any additional updates in the space below:

Providers Name:	NPI:	Date Employment Ended:

Please forward to: CCPNSupport@communitycarenc.org Fax: 919-745-2352 Rev. January 2022

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Providers to Add

If provider practices in more than two locations, please continue on next line.

Provider Name:	Provider NPI:	Specialty:	Licensure Type:	CAQH#	Panel Accepted: (Y/N) Medicaid	Medicare	Email Address:	Date Employed:	Primary Site Location:	Secondary Site Location:

Signature: _____ Title: _____

Print Name: _____ Date: _____

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