THE OHIO STATE UNIVERSITY
HEALTH PLAN

Provider Information Form (PIF) Instructions

ACTION	YOU WILL NEED TO COMPLETE THE SECTIONS IDENTIFIED BELOW ON THE PROVIDER INFORMATION UPDATE FORM (PIF) AND INCLUDE ANY ADDITIONAL DOCUMENTS LISTED. ALL DOCUMENTS MUST BE COMPLETED AND RETURNED. PLEASE BE SURE TO INCLUDE THE EFFECTIVE DATE OF THE CHANGE IN THE TOP RIGHT CORNER OF THE FORM.
Add a provider to the group	▪ PIF- Complete Sections A through C ▪ Complete CAQH ▪ Current Malpractice Face Sheet
Term a provider from the group	▪ PIF- Complete Sections A and B
Change Phone/Fax	▪ PIF- Complete Sections A and B
Change the Pay-To/Billing Address	▪ PIF- Complete Sections A through C
Change or add a service location	▪ PIF- Complete Sections A through C
Change group name	▪ PIF- Complete Sections A and B ▪ W-9
Change individual provider name due to marriage or divorce	Send request on company letterhead with effective date
Change Tax ID	Contact OSU Health Plan Provider Network Services at OSUHealthPlanPR@osumc.edu
CREDENTIALING INFORMATION	**YOU WILL NEED TO…**
If you have a CAQH number	Complete CAQH Provider Data Form. You also need to update and give OSU Health Plan permission to review. Visit the website at http://www.caqh.org.
If you don't have a CAQH number	Go to http://www.caqh.com to request a CAQH number and fill out the information. You will need to give permission to OSU Health Plan to review.
CONTACT INFORMATION	If you have additional questions please contact OSU Health Plan Provider Network Services at OSUHealthPlanPR@osumc.edu

Please submit form to osuhealthplanpr@osumc.edu or fax (614)-292-1166

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This form is imaged. Please print with black ink or fill in using Acrobat®Reader®.
Please use additional forms for each Federal Tax Identification Number (TIN).

Page ____ of ____
Info Effective Date_____

REASON

Check One: ☐ Add ☐ Delete ☐ Address/Fax/Phone Change

Check One: ☐ PCP ☐ Specialist ☐ Hospitalist ☐ Group ☐ Hospital/Facility ☐ Ancillary

A — IDENTIFICATION INFORMATION

Group Name/Individual Provider Name				CAQH Number
Individual NPI No.				
Primary Specialty				List Specialty in Directory? ☐ Yes
Secondary Specialty	List Specialty in Directory? ☐ Yes	Accepting New Patients ☐ Yes ☐ No	Gender ☐ Male ☐ Female	Date of Birth

B — SERVICE LOCATION INFORMATION

TIN	Facility or Group Name		List Location in Directory? ☐ Yes
Address (Street, City, State & Zip)			Country
Office Phone for Appointment	Fax	Specialty	Group NPI No.

Correspondence Address (Street, City, State & Zip) Fill in here or use same as: ☐ Remittance Address ☐ Service Location

ADDITIONAL SERVICE LOCATION

Facility or Group Name, if different than above	Correspondence Email		List Location in Directory? ☐ Yes
Address (Street, City, State & Zip)			Country
Office Phone for Appointment	Fax	Specialty	Group NPI No.

ADDITIONAL SERVICE LOCATION (Please complete another form for any additional locations.)

Facility or Group Name, if different than above	Correspondence Email		List Location in Directory? ☐ Yes
Address (Street, City, State & Zip)			Country
Office Phone for Appointment	Fax	Specialty	Group NPI No.

C — REMITTANCE ADDRESS INFORMATION

Reimbursement Name (Legal Name on W-9)	Reimbursement Entity's TIN

Type of Entity (Please check) ☐ Individual / Sole Proprietor ☐ Corporation ☐ Partnership ☐ Other

I certify under penalty of perjury that the Tax Identification Number I have provided is correct.

Street Address / P.O. Box

City	State	Zip + 4	Phone	Fax

Additional comments/reason for submitting form: ☐ **Check here if Provider credentialing needed**

Office Manager or Administrator	Phone	Email Address	Today's Date

Please submit form to osuhealthplanpr@osumc.edu or fax (614)-292-1166