Provider Maintenance Form Instructions

Keeping Provider Records Up To Date
Where is the PMF


2) Please go to upper right margin and select “providers” and hit enter. It will be the first link.

3) Next page. Please enter your state in the middle of the page, and then hit enter.

4) Once there, please locate the blue bar towards the top of the page, go to the 4th bar, labeled “Answers@Anthem,” this is a drop down box and then click the 2nd link which is the “Provider Maintenance Form”.

5) Next Page: Please click on “Online Provider Maintenance Form.” Always answer “NO” to the question that pops up.
Section A- General Information

- Please fill out all highlighted sections.
  - If you do NOT know your ANTHEM Provider ID Number/PIN, then please just enter 12 “9’s” ex. 999999999999

This site gives you the capability to submit the Provider Maintenance Form electronically.

<table>
<thead>
<tr>
<th>Section A - General Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Complete required fields for tax identification number and the practice name.</td>
</tr>
<tr>
<td>2. Specify solo or group practice. If group practice, indicate the number of physicians in the group.</td>
</tr>
<tr>
<td>3. Specify if you would like to receive Rapid Updates from Anthem via email/fax.</td>
</tr>
</tbody>
</table>

Practice Tax ID Number (EIN/SSN):
Group/Practice Name:
If paper claim submission or exempt from NPI fill out Legacy ID or Anthem PIN number. IN, KY and OH Provider Id Number/PIN:
Missouri Provider Id Number:
Wisconsin Provider Id Number:
Group National Provider Identification Number:
Solo or Group Practice:
If Group Practice, # of physicians in practice:
Would you like to receive Rapid Updates from Anthem via email/fax?

Please don’t forget to subscribe to Rapid Updates!
Section B-Reason for Submitting

- Please click all reasons for submitting. If you’re deleting a provider, please indicate why (i.e. Provider left group)
  - The effective date is required.
Section B – Reasons for Submitting

- **Adding provider**: To add a provider to a group.
- **Deleting Provider**: To delete a provider from a group (must supply reason in the text section below.)
- **Adding location**: Use if adding a location to a group and/or a provider in a group.
- **Adding provider to location**: Adding provider to an existing location in a group.
- **Add NPI**: Can be used to add a provider NPI or to add a group NPI.
- **Specialty change**: Used to notate a change in provider specialty.
- **Provider name change**: Used to change a provider name. For example, if a provider were to get married.
- **Deleting location**: To remove a specific location from a provider or group record.
- **Changing office hours**: Used to notate a change in a provider or group office hours.
- **Change NPI**: Used to change specific group or provider NPI.
Section B – Reasons for submitting, cont.

- **Practice Name Change:** To change a practice name. This name is what will appear in the provider directory.

- **Practice Address/Phone change:** To change a group or provider address and/or phone number in the system.

- **Deleting Provider from Location:** To remove a provider from a group location.

- **Name for Payment Change:** To change the name of the person receiving remit payments.

- **Address/Phone number for Payment Change:** To change the remittance/payment address for a group. Only one remittance/payment address is permitted per group.

- **Tax ID Change:** To change the tax ID for a group or provider. Please be sure to supply the old tax ID in the space provided at the bottom of section B.

- **Add/Update Provider’s Self-Reported Areas of Expertise:** To notate a provider’s self-reported areas of expertise.

- **Add/update Patient Information:** To notate which patient groups the provider specializes in.

- **Options to select will be in section I and J of the provider maintenance form.**
  
  *For behavioral health providers only.*
Section C – Provider Information
Used to capture all information when adding a provider.

- All highlighted fields below are required but please try to answer all fields for most accurate entry in the system.

<table>
<thead>
<tr>
<th>Section C – Provider Information (Most fields required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Include provider name (name submitted must match name format on 1500 HCFA form), title, Social Security number, date of birth, gender, specialty, professional license number and CAQH Id (specific to Credentialing).</td>
</tr>
<tr>
<td>2. To update multiple providers, complete and submit this form for each provider.</td>
</tr>
<tr>
<td>3. * indicates required fields for physician update.</td>
</tr>
</tbody>
</table>

- Provider First Name: [Field]
- Provider MI: [Field]
- Provider Last Name: [Field]
- Title (MD/DO/etc.): [Field]

Please select one of the following specialties:
- Primary Specialty Physician (i.e. FPR, HNM)
- Other (i.e. PA, CRNA, CRNM)

Please choose your appropriate specialty:
- Specialty Care Physician (i.e. Cardiology, Gen. Surg.)
- Clear Selection

- Are you a:
  - Locum Tenen
  - Hospital Based Physician
  - Hospitalist
  - Clear Selection

- Is the provider Board Certified for the specialty listed?
  - Yes
  - No
  - Not applicable to specialty

- If no, when will you be sitting for the exam?

- Radiology Office Based Setting if applicable:
  - Hospital Based Setting
  - Free Standing Center

- Social Security Number: [Field]

- Professional License Number: [Field]

- Medicare Opt Out: Does this provider participate in Traditional Medicare?
  - Yes
  - No
  - Not applicable to specialty

- Applied Date: [Field]
Section C – Provider Information, cont.

☐ All highlighted fields below are required but please try to answer all fields for most accurate entry in the system.

Medicare Opt Out:
- Does this provider participate in Traditional Medicare?
  - Yes
  - No
- Applied Date:
  - Have they opted out of Medicare?
  - Effective Date of Medicare opt out:
  - (mm/dd/yyyy or N/A)

CAQH ID Number:
- * Date of Birth:
- * Gender:

Accepting new patients?
- * Age Restriction:
Indicate service type provided:
- Medical
- Dental
- Vision
- Other

Do you utilize a Nurse Practitioner or Physician Assistant in your practice? ☐ NP ☐ PA ☐ N/A

Indicate if you are a: (If checked Medical above, this section required)
- Individual Practice (solo provider)
- Federally Qualified Health Center
- Urgent Care
- Department of Health
- Retail Health Clinic
- Group Practice (more than one provider)
- Rural Health Clinic
- Prenatal Care Coordinator
- Walk in Doctor's Office
- NP Supporting a Specialist
- PA Supporting a Specialist
- Certified Midwife
- ECP - Essential Community Provider
- Clinic (Type)

If Clinic selected, please specify Clinic Type

Please select your ethnic origin (**Optional)
- ☐ Asian Indian
- ☐ Native American (i.e. American Indian, Eskimo, Aleut, or Native Hawaiian)
- ☐ African-American
- ☐ Clear Selection
- ☐ Pacific Asian
- ☐ Hispanic
- ☐ White, Non-Hispanic
Section D – Providers of Autism Only

Only required if you are an Autism Provider. See highlighted box below.

Indiana Providers:
If you are a Certified Behavioral Analyst or a Certified Assistant Behavioral Analyst who provides services under Indiana statute §27-8-14.2, please attach a copy of your BACB certification with this PMF.

Kentucky Providers:
If you are a licensed Behavioral Analyst or a licensed Assistant Behavioral Analyst under Kentucky HB 159 Section 8, please include your license number in Section C of this form.

Ohio Providers:
If you are a Certified Behavioral Analyst or a Certified Assistant Behavioral Analyst under Ohio Habilitative Services, please attach a copy of your BACB certification with this PMF.

Missouri Providers:
If you are a Board Certified Behavior Analyst or a Board Certified Assistant Behavior Analyst under Missouri statute § 337.300, et seq., R.S.Mo, please include your license number in Section C of this form.

Wisconsin Providers:
If you are a psychiatrist, psychologist, licensed clinical social worker, speech therapist or occupational therapist qualified to provide autism services please follow the instructions below.

If you are a qualified provider of autism services under Wisconsin Statute 632.895(12m) please complete the Qualified Autism Provider Certification. Log into www.Anthem.com, (1) choose Provider (2) choose WI in the state drop down and click the enter button (3) expand the Answers@Anthem menu and click the link to the Provider Forms page (4) print off the appropriate Qualified Autism Provider Certification and fax to 262-523-4783 or attach to this PMF.

Section E – Practice Address (Required)

1. If practice address or address for payment change, enter your old practice address and address for Payment here and your new practice address and address for payment in Section F.

or

2. If adding practice, enter your office location and your address for payment (if different from practice address).

3. It is unacceptable to put “same”, “same as practice address” or “see above” in the address for payment. Any of these entries will be rejected.

3. Missouri House Bill 1498 requires the health plan, when requesting additional information for the purpose of determining if all or part of a claim will be reimbursed, to request such information via electronic or facsimile notice. Please provide the fax and email for the appropriate department within your organization that would handle these types of requests.

4. If you need help finding your 9 digit Zip Code, go to USPS.com® - ZIP Code™ Lookup for additional information.

5. Phone numbers for Practice address should be the phone number that patients would call to make an appointment.
Section E – Practice Address Information

☐ This is the space for the provider’s primary practice information. Please note that you can select highlighted box if remit address is same as practice address.

If you are a qualified provider of autism services under Wisconsin Statute 632.895(12m) please complete the Qualified Autism Provider Certification. Log into www.Anthem.com, (1) choose Provider (2) choose WI in the state drop down and click the enter button (3) expand the Answers@Anthem menu and click the link to the Provider Forms page (4) print off the appropriate Qualified Autism Provider Certification and fax to 262-523-4783 or attach to this PMF.

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   or
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5. Phone numbers for Practice address should be the phone number that patients would call to make an appointment.

| Street Address: |
|City: |
|State: |
|Zip: |
|County: |
|Phone Number(for patient appointments): |
|Fax Number: |
|Group Email Address: |

Address for Payment Information **Required**

| Same as Practice Address ✓ |

| (99999-9999) |
| (99999-9999) |
| (99999-9999) |
Section F – Address Information Change

*Only complete this section if you are changing an address*

☐ Enter the new address information in this section. Current address should be entered in section E.

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Section F – Address Information Change (Complete only if changing address.)

1. Enter your new practice address and address for payment here. (Both are required.)

2. It is unacceptable to put “same”, “same as practice address” or “see above”. Any of these entries will be rejected.

3. If you need help finding your 9 digit Zip Code, go to USPS.com® - ZIP Code™ Lookup for additional information.

4. Phone numbers for Practice address should be the phone number that patients would call to make an appointment.

Practice Address Information:

Street Address:
City:
State:
Zip: 
(99999-9999)
County:
Phone Number(for patient appointments):
(9999999999)
Fax Number:
(9999999999)
Group Email Address:
Languages spoken by Office Staff:
Email Address for Payment:
Contact Name for Payment:

Access to Public Transportation? ☐ Yes ☐ No
Handicap Accessible? ☐ Yes ☐ No
Evening Hours? ☐ Yes ☐ No
List this address in the Provider Directory? ☐ Yes ☐ No
Time Zone of Office Hours?

Days office is open?
☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

Address for Payment Information **Required
Same as Practice Address ☐
Remit for this Practice Address is same as Section E ☐
Section G – Additional Office Locations

Enter all additional offices for the provider below. Primary address of the provider should still be listed in section E and only one remit address is permitted. Please select box in the highlighted section below to enter remit information for additional locations.

1. Include any additional office locations.
2. Submit as many forms as needed to include additional addresses that do not fit in this form.
3. It is unacceptable to put “same”, “same as practice address” or “see above”. Any of these entries will be rejected.
4. If you need help finding your 9 digit Zip Code, go to USPS.com®-ZIP Code™ Lookup for additional information.
5. Phone numbers for Practice address should be the phone number that patients would call to make an appointment.
Section H - Covering Physicians
*For PCPs and OB/GYNs in HMO networks ONLY.

Please fill out the section below only if you are a PCP or OB/GYN in the HMO network with covering physicians.

1. List all physicians that cover for you.

2. Submit as many forms as needed to include additional covering physicians that do not fit in this form.

3. If you need help finding your 9 digit Zip Code, go to USPS.com® - ZIP Code™ Lookup for additional information.

First Covering Physician

- Group Entity Name
- Address:
- City:
- State:
- Zip: [99999-9999]
- Specialty
- Nins(9) Digit Tax ID: [999999999]
- Effective Date: [mm/dd/yyyy]
Section I – Patient Information
Section J – Provider’s Self Reported Areas of Expertise

☐ Only fill out the sections below if you are a behavioral health provider. Corresponds with section B.

### Section I - Patient Information (Note: For Behavioral Health Providers Only)

- Children
- Senior Adults (Ages 60+)
- Adolescents (Ages 13-17)
- Adults (Ages 18+)
- Plants
- Deaf/Hearing Impaired
- Disabled Persons

Do you require patients be evaluated by a non-Psychiatrist (psychologist, counselor or social worker) prior to scheduling an appointment for the in-office appointment?
- ☐ Do you see patients on an inpatient basis
- ☐ Do you see patients on an outpatient basis
- ☐ Both
- ☐ Clear Selection

### Section J - Providers’ Self-Reported Areas of Expertise (Note: For Behavioral Health Providers Only)

- ADD/ADHD
- Adoption
- Anxiety and Panic Disorders
- Autism/PDD/Asperger's (MI Providers see Section D)
- Bariatric Surgery
- Behavior Modification
- Bipolar
- Brief Solution Focused
- Chemical Dependency
- Chemical Dependency Assessment
- Christian Counseling
- Compulsive Gambling
- Cultural/Ethnic Issues
- Depressive Disorders

- Dialectical Behavioral Therapy
- Divorce/Blended Family Issues
- Domestic Violence
- Eating Disorders
- Electroconvulsive Therapy
- End of Life Issues
- Family Therapy
- Gay/Lesbian Issues
- Group Therapy
- HIV/AIDS Related Issues
- Infertility
- Medication Management (Only those providers who are contracted and allowed to prescribe in your state)
- Men Issues

- Neuropsychological Testing (Only those providers who are contracted and allowed to test in your state)
- Obsessive Compulsive Disorder
- Pain Management
- Personality Disorders
- Postpartum Issues
- Post Traumatic Stress Disorder (PTSD)
- Prenatal Issues
- Psychological Testing (Only those providers who are contracted and allowed to test in your state)
- Schizophrenia/Schizoaffective Disorder
- Sexual Abuse
- Sexual Disorders
- Victims of Abuse, Assault, Trauma
Section K - Attachments

- Upload any additional materials that may be helpful to the Provider Solutions representative to process your PMF.
- For example, additional locations that didn’t fit in section G, credentialing material, licensure, etc.
  - *Nothing is required in this section.*
Section L - Comments

- Please review all information on the form and then certify that it is correct below. Be sure to leave a contact name, phone number, and email address. See example below.
Submitting Provider Maintenance Form

Once you hit submit, you will receive a confirmation number. Please see the example below:

Your provider maintenance form has been successfully submitted.

Thank you for your submission for Test Group today
October 30, 2014. Your submission number is 300717

Click to return to Provider Maintenance Form entry page

Please allow 3-4 weeks for processing.