OPA NETWORK INFORMATION CHANGE FORM

OPTIMUM PHYSICIAN ALLIANCE™

Practice Information

Group Name_____ Tax ID_____

Summary of Changes

(please indicate the purpose of this notice by checking all that apply)

☐Provider Update — New ___ Terming ___ Effective Date_____

☐Add a Location — Effective Date_____ Tax ID_____
Please note, nursing homes are not a part of the OPA network at this time.

☐Terming Location — Effective Date_____ Tax ID_____ Reason_____

☐Address Correction — Effective Date_____ Tax ID_____
Applies to: Physical address___ Remit Address___ Correspondence Address___

☐Tax ID Change — Effective Date_____ New Tax ID_____ Previous Tax ID_____
Is tax ID change related to a change in ownership? Y___ N___

☐PCMH Update — Location Name_____ Recognition Status____ New Recognition Notice___
Please attach a copy of your Notification of Recognition email from NCQA.

Provider Information

Provider Name_____

NPI _____

License#_____

Email_____

Work Phone_____

Cell Phone_____

Title MD____ DO_____ *NP_____ *PA_____

Specialty_____

*Collaborating Physician_____

Fellowship Y___ N___ Resident Y___ N___

Inpatient Only Y___ N___

Kaleida Privileges/Hospital Agreement Y____ N____

Number of clinical hours practiced per week_____

New Location / Correct Location Information

_____
Address

_____
City State Zip

_____ _____
Phone Fax

_____ _____
Email Tax ID

Previous Location / Incorrect Location Information

_____
Address

_____
City State Zip

_____ _____
Phone Fax

_____ _____
Email Tax ID

Name of person completing this form:_____Phone:_____

Signature of person completing this form:_____ Date:_____

Please return to the following email: OPANetworkOperations@opawny.com – Thank you!