Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

PROVIDER INFORMATION FORM

Use this form to register and/or update your provider information (e.g., service location(s), payment address, tax identification number, etc.) with Gold Coast Health Plan (GCHP). Please complete all applicable sections. Providing complete and legible information will expedite your request and help ensure accurate processing. The completed form should be returned by email to ProviderRelations@goldchp.org ATTN: Provider Relations Department.

Section 1: Provider Information

Provider's First Name:	Provider's Last Name:	Title / Type of Licensure (i.e., MD, DO):
Group Association Name:		Effective Date of Request (MM/DD/YY):
Date of Birth:	Individual NPI: Supervising Physician's Individual NPI Number (applies only to Physician Extenders):	Corporate NPI:
CAQH Provider ID (physicians only):	Medical License Number:	Tax ID Number:
☐ PCP ☐ Specialist ☐ Physician Extender (i.e. NP, PA) ☐ Hospital-Based Professional (Only chose one)	Primary Specialty Type: Board Certified (Y/N): Taxonomy Code:	Secondary Specialty Type: Board Certified (Y/N): Taxonomy Code:
Patient Age Limits: From To	Patient Gender Limits: ☐ Male ☐ Female ☐ Both	PCP Only Total Capacity (50 - 2,000): (Must choose a minimum of 50 / maximum of 2,000)
Office Contact Name:	Contact Telephone Number:	*Contact Email Address:

* Legal documentation is required for changes to last name (e.g., marriage license).
* Only Primary Specialty will be listed in provider directory.
* Please provide your current email address to receive GCHP Memos, Provider Operation Bulletins, and/or other essential alerts from the Plan.

NOTE: FOR SECTIONS 2-6, COMPLETE ONLY THE SECTION(S) THAT REQUIRES A CHANGE.

Section 2: Languages Spoken

List non-English languages spoken by the provider and/or staff in order of fluency. Check 'P' for Provider and 'S' for Staff.

1 _____ P ☐ S ☐ **2** _____ P ☐ S ☐ **3** _____ P ☐ S ☐

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Section 3: Service Location

Please complete a separate form for each additional location or attach a company roster that includes the requested information below.

☐ Add new location / provider ☐ Relocated ☐ Expired location ☐ Correction to existing location

☐ Initial Add ☐ Office Location ☐ Hospital Based Location

☐ Other (Independent Diagnostic Center, Supplier, etc.): _____

SERVICE LOCATIONS, TIME ALLOCATION AND PERCENTAGE OF TIME

Please complete a separate form for each additional location or attach a company roster that includes the requested information below.

Primary location ☐ Exclude from Provider Directory			Secondary location ☐ Exclude from Provider Directory		
Location Name (if different than Group Association Name above):			Location Name (if different than Group Association Name above):		
Accepting New Medi-Cal Members (GCHP Members): ☐ Yes ☐ No ☐ Existing Patients Only			Accepting New Medi-Cal Members (GCHP Members): ☐ Yes ☐ No ☐ Existing Patients Only		
Percentage of Time Allocated to GCHP Member: %			Percentage of Time Allocated to GCHP Member: %		
Street Address:			Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Primary Location		Secondary Location	
Telephone Number:	Fax Number:	Telephone Number:	Fax Number:
Email Address (if different than Section 1):		Email Address (if different than Section 1):	
Location NPI (if different than Corporate NPI):		Location NPI (if different than Corporate NPI):	

Primary Location Office Hours

	M	T	W	Th	F	Sat	Sun
A.M.							
P.M.							

Percentage of Time Spent at Primary Clinic: %

Total No. of Medi-Cal / GCHP Members provider will accept at primary location:

(If multiple locations, please enter unique number for each location).

Secondary Location Office Hours

	M	T	W	Th	F	Sat	Sun
A.M.							
P.M.							

Percentage of Time Spent at Secondary Clinic: %

Total No. of Medi-Cal / GCHP Members provider will accept at secondary location:

(If multiple locations, please enter unique number for each location).

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Section 4: Payment / Billing Address

☐ Check box if billing address is the same as the service address.

A signature at the bottom of this form by the Tax ID owner is required for all payment address changes.

Current Address (Check ☐ PRIMARY or ☐ SECONDARY)			Former Address (Changes only)		
Provider Name (last, first, middle initial / business name):			Provider Name (last, first, middle initial / business name):		
Street Address:			Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Telephone Number:	Fax Number:		Telephone Number:	Fax Number:	
Email Address:			Email Address:		

Section 5: Tax Identification Number / Employer Identification Number (TIN / EIN)

If joining a participating group, please use the group's TIN to associate the request with the participating group.

In order to update your Tax ID number, a completed W-9 must be attached to this form.

Current TIN / EIN:	Former TIN / EIN (change only):	Effective Date of TIN Change:

Section 6: Hospital Affiliation Update

A hospital privilege letter from the facility along with written notification from the provider's office (administrator, manager, provider, etc.) and/or attestation form for hospital-based physicians is required.

** If no hospital privileges, please provide a letter or copy of an agreement with a provider that will admit for you.

Hospital Name	* Hospital OSHPD ID	Hospital NPI	Add / Delete?	Effective / Expiration Date
(1)			Add ☐ Delete ☐	
(2)			Add ☐ Delete ☐	

* Hospital Office of Statement Health Planning & Development (OSHPD) number

NOTE: A signed Payment Authorization (PA) Form must be completed when: (1) adding a provider, (2) a provider joins a group.

Additional Comments:

Print Name of Physician / Provider: _____

Signature of Physician / Provider: _____ Date: _____