St. Luke's Health Partners

Provider Update Form

BRIGHT PATH

☐ Provider Add/Change Location ☐ Provider Termination ☐ Facility Based Provider Application
☐ Group Add/Change Location ☐ Group Termination

Provider Information

Provider Name and Title			
Social Security No.	Foreign Languages spoken by Provider	❑ Male ❑ Female	Date of Birth
Individual NPI	State License # (attach copy)	DEA No. (attach copy)	PTAN
Which primary specialty are you practicing at this location?	Additional Specialties	Facility Privilege(s) or Admit Plan	
Does above provider practice at another Group/Tax ID? ☐ Yes ☐ No If Yes, what % of provider's time is spent at Group listed below:			

Location Information ☐ Add Location ☐ Term Location Effective Date at Practice Location_____

Location Name	Location Address: Street, City, State & Zip	
Entity Legal Name	Location Phone	Location Fax
Tax ID	Type 2 Organizational NPI	
Is your practice handicapped accessible? ❑Yes ❑ No	Is this your primary practice location? ❑Yes ❑ No	
Notice Address (if different from billing or location address)	Billing address (if different than service address)	
Billing Phone	Billing Fax	
If changing locations, indicate what address should be eliminated:		
Credentialing Contact	Credentialing Contact email Address	

Clinic Hours of Operation for this Location (not provider specific)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From_____To_____	From_____To_____	From_____To_____	From_____To_____	From_____To_____	From_____To_____	From_____To_____

Practitioner Information at this Location:

Are you a PCP at this location? ❑ Yes ❑ No

Do you provide Telehealth services at this location? ❑ Yes ❑ No

Do you practice Urgent Care at this location? ❑ Yes ❑ No

Are you SAMHSA certified for Medication-Assisted Treatment (MAT)? ❑ Yes ❑ No

Do you see members by appointment at this location? ❑ Yes ❑ No

Patient Parameter: ❑ Male only ❑ Female only ❑ Both Min Age_____Max Age_____ Date of last Cultural Sensitivity Training: _____

Accepting new patients in the following lines of business:

Commercial Payers ❑Yes ❑No Medicare Advantage ❑Yes ❑ No

Accepting Medicare/Medicaid Insurance: ❑ Yes ❑ No

Do you opt out of Medicare: ❑ Yes ❑ No Start Date:_____End Date: _____

Do you opt out of Medicaid: ❑ Yes ❑ No Start Date:_____End Date: _____

Completed By (Required)

Completed By	email
Title	Phone

Submit via email to ***SLHealthPartners@slhs.org***