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	Race	Ethnicity
	☐ American Indian ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Prefer not to disclose	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to disclose

Social Security No.	Languages spoken other than English	Gender Identity	Date of Birth
		☐ Male ☐ Non-binary ☐ Female ☐ Transgender ☐ Prefer not to disclose	

Individual NPI	State License # (attach copy)	DEA No. (attach copy)	PTAN

Which primary specialty are you practicing at this location?	Provider Email	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 ☐ Term Provider from Tax ID

Effective Date at Practice Location _____

Location Name	Location Address: Street, City, State & Zip

Entity Legal Name	Location Phone	Location Fax	On average, how soon can a new patient get an appointment?
			☐ Within 48 hours ☐ Within 2 weeks ☐ 2-4 weeks ☐ 4-6 weeks ☐ Beyond 6 weeks

Tax ID	Type 2 Organizational NPI

Is your practice handicapped accessible? ☐ 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

Do you offer Interpretation Services? ☐ Yes ☐ No

Patient Parameter: 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***