



PROVIDER UPDATE REQUEST FORM

Please use this form to inform FCA of any adds, changes, &/or terms within your office. *This only applies if the provider has already been credentialed or effective with FCA.*

*DATE (of request): _____ *EFFECTIVE DATE (of update): _____

*UPDATE TYPE (please check): ADD CHANGE TERMINATION

*TAX ID #: _____ *NPI #: _____ *MEDICAID #: _____

*NPI 2#: _____ *MEDICAID GRP#: _____

*PROVIDER NAME: _____

DEGREE: MD DO PA-C ARNP OTHER (specify) _____

OFFICE NAME: _____

ADDRESS: _____

CITY/STATE/ZIP+4: _____

PHONE #: _____ FAX #: _____

OFFICE HOURS: _____ AGES SEEN: _____

PRACTICE STATUS (please check): BH PCP SPECIALIST HOSPITALIST COVERING

Office Contact Info: _____

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UPDATE INFORMATION: Provide a detailed explanation of the change/update you would like FCA to process (use additional paper if necessary or add any documents necessary to process request)

Please complete a separate request for each provider in your organization. Return form to Davina Butler, Network Operations Specialist at 904-244-9409 (fax) or davina.butler@jax.ufl.edu