St. Luke's Health Partners

Provider Update Form

BRIGHT PATH

❑ Provider Add/Change Location*
❑ Group Add/Change Location*
❑ Provider Termination
❑ Group Termination
❑ Facility Based Provider Application*
**attach malpractice coverage policy face sheet*

Provider Information

Provider Name and Title			
Social Security No.	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	
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

If changing locations, indicate what address should be eliminated:

Mail Address (if different from billing or service address)	Billing address (if different than service address)
Billing Phone	Billing Fax
Contracting Contact	Contracting Contact email Address

Hours of Operation for this Location

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 practice Urgent Care at this location? ❑ Yes ❑ No

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

Do you have e-prescription capability at this location? ❑ Yes ❑ No

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

Are you SAMHSA certified for Medication-Assisted Treatment (MAT)? ❑ 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*** or fax to (208) 381-9444