Please fill out all necessary fields based on request, and return via fax (702) 522-1357 or email to WH_Contracting@hcpnv.com

Notice of Change

(NOC)

General Information

Practice Name (DBA) _____

Legal Entity Name (if different from above) _____

Tax ID # _____ Group NPI _____

Practice Manager _____

Phone _____ Fax _____

Email _____ Date _____

NOC PROVIDER (select one):

☐ **ADD*** ☐ **CHANGE** ☐ **TERM**

Name _____ NPI _____

Specialty _____ License # / Expiry _____

Sub-Specialty _____ CAQH # _____

Hospital Based? YES ☐ NO ☐ Gender _____

Languages Spoken _____ Effective Date _____

Practice Location(s) - Please list all locations **this provider** will practice at. _____

Address(es): _____ Phone: Fax:

_____ Phone: Fax:

_____ Phone: Fax:

Providers may **NOT see members until they have received an Effective Date Letter following credentialing completion**

NOC LOCATION (select one):

☐ **ADD** ☐ **CHANGE** ☐ **TERM**

Location Type ☐ Primary ☐ Billing ☐ Other _____

Address _____ Phone: Fax:

Administrative Use Only

Date Received:

Previously credentialed: ☐ Yes ☐ No