

Contract Change Form Network Management

Section A.1: PROVIDER INFORMATION REQUEST:

NPI: _____ Name: _____

Specialty1: _____ Specialty2: _____ Specialty3: _____

*Provider email: _____ *Provider Cellphone: _____

**Administrative use Only*

Section A.2: CONTACT CURRENT INFORMATION:

*Contact Person: _____

*Title Contact Person: _____

*Email: _____ *Cellphone: _____, Telephone: _____ Ext.: _____

*Mailing Address: _____ City: _____ St: _____ Zip Code: _____ - _____

Section A.3: TYPE OF REQUEST:

- | | |
|---|---|
| <input type="checkbox"/> Demographics Changes in contract Information <i>(Only A.4, A.5, or A.6)</i>
<input type="checkbox"/> Add a New Facility, Office or Location
<input type="checkbox"/> Change of Individual to Corporation
<input type="checkbox"/> Change of Ownership
<input type="checkbox"/> Add a new Specialty: _____
<input type="checkbox"/> New Group
<input type="checkbox"/> Change of Specialty: _____
<input type="checkbox"/> Exclusion (include letter)
<input type="checkbox"/> Inclusion to Group <i>(proceed with SECTION B)</i> | <input type="checkbox"/> Add Line of Business (LOB)
<input type="checkbox"/> Add Services: _____
<input type="checkbox"/> Change of Corporation to Individual
<input type="checkbox"/> Change Tax ID (include letter)
<input type="checkbox"/> Change NPI:
Old NPI: _____
*New NPI: _____
*(Provider need complete Contract Request Form)
<input type="checkbox"/> Red Selective: <input type="checkbox"/> Imaging <input type="checkbox"/> Laboratory
<input type="checkbox"/> Other: _____ |
|---|---|

Section A.4: LINE OF BUSINESS:

Which line(s) of business do you want to add to your contract? Triple-S (Commercial) Triple-S (VITAL) Triple-S (Advantage)

Indicate which line(s) of business you are currently active: Triple-S (Commercial) Triple-S (VITAL) Triple-S (Advantage)

Section A.5: MAILING ADDRESS: Please provide information (if apply) * New Delete Modify

Mailing Address: _____

City: _____ St: _____ Zip Code: _____ - _____ Cellphone Number: () _____ Fax Number: () _____ - _____

Email: _____

Section A.6: PHYSICAL ADDRESS: Please provide information (if apply) * New Delete Modify

Physical Address 1: _____ City: _____ St: _____ Zip Code: _____

Accept New Patients Yes No Handicap Access: Yes No E-prescribing: Yes No

Office Phone Number: _____ - _____ Fax number: _____ - _____ Email: _____

Contract Change Form Network Management

Section A.7: OFFICE HOURS:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM IN							
AM OUT							
PM IN							
PM Out							

Section B: FOR INDIVIDUALS ONLY:

*Provider Name: _____ NPI: _____
Last Name(s) Name Initial

Medicaid Provider? No Yes, Please Include Number _____, Medicaid Management Information System (MMIS). **Medicare Provider?** No Yes, Please Include Number _____, Provider Transaction Access Number (PTAN).

*Corporation Name: _____ Corporation NPI: _____

*Are you a: CSP / PSC / PC or CRL/LLC INC CORP **Medicaid Provider?** No Yes, Please Include Number _____, Medicaid Management Information System (MMIS). **Medicare Provider?** No Yes, Please Include Number _____, Provider Transaction Access Number (PTAN).

*Corporation Documents Included? No Yes, check below all the documents

- Tax ID/ Patronal Social Security NPI Registry Certificate Good Standing Certificate Incorporation Certificate
 Other: Specify, _____

Are you part of any Group, IPA or PMG? No Yes; If yes, please complete this section:

Group Name: _____ Group NPI: _____

Are you a PCP? No Yes; If yes, please complete this section:

Group Name: _____ Group NPI: _____

*Are you certified by Department of Health for administer sedation or general anesthesia? *

Yes (dentist Only) No N/A

Are you certified by Department of Health for Radiation license (X-Ray)?

(if apply: Dentist, Chiropractic, Optometry, Podiatry)

Yes: _____ No: _____ Specialty: _____ #License _____

Are you certified in telehealth or telemedicine?

Yes: _____ (include certification) No: _____

Section C: FOR NON-INDIVIDUALS ONLY:

*Facility Name: * _____ NPI: _____

*Specialty: _____ *Medicaid Number: No Yes, _____ Please Provide Number **Medicaid Management Information System (MMIS)**. *Medicare Provider: No Yes, _____ Please Provider Number **Provider Transaction Access Number (PTAN)** Are you certified in telehealth? Yes: _____ (include certification) No: _____

Contract Change Form Network Management

***Type of provider**

- Ambulance
- Type I Type II Type III Air
- Ambulatory**
 - Facility Surgical Clinic/Center Chemotherapy
- Blood Bank**
- Dialysis Center**
- DME**
 - Implants**
 - Orthopedic Cardiovascular Mesh
- Emergency Room / Urgent Care Facility**
 - *24 hours availability? Yes No, if no specify
 - X-Ray Laboratory* _____
- *Include evidence of registration to share results.**
- Home Health Agency**
- Home Infusion**
- Hospice**

- Hospital**
- Imaging Center**
 - Advanced Imaging (**Hitech Images** - MRI/MRA, CT, PET, Nuclear Medicine, Mammography, Ultrasound)
 - Other: Specify: _____
- Infusion Center**
- Laboratory**
 - Clinical Genetics Special Procedures
 - *Include evidence of registration to share results.**
- Non-Emergency Transportation**
- Preventive Clinic**
- Prosthesis & Orthosis Supplier**
- Skilled Nursing Facility**
- Specialized Pharmacy**
- Vaccination Center**
- Vision Center**
- Wound Care**
- Alternative Medicine**
- Bariatric Excellence Center**
- Da Vinci (Robotic Surgery)**

If **Hospital**: List Other NPI's or subparts are attached to your facility:

NPI: _____

Specialty: _____

Section D: Authorization:

Authorized Signature: _____
 (if not a physician)

Print Name: _____

Date: _____

Title of Authorized: _____

Contract Change Form Network Management

Please **SEND** this form to contrataciones@ssspr.com or our mailing address:

Network Management Contracting Department

Po Box 363628 San Juan, PR 00936-3628

Section A.1: PROVIDER INFORMATION REQUEST

1. This Section the provider needs to provide the correct information: NPI, Legal Name (individual, Corp, Group, etc.).
2. Specialties provider
3. Provider Contact: email and cellphone.

Section A.2: CONTACT CURRENT INFORMATION

4. This section **MUST** be completed by ALL requestors. The information in this section may be used by Triple-S if any additional information is required.
5. **Contact Person** Full name of contact person.
6. **Title Contact Person**
7. **Email** Include contact person's e-mail address to which evaluation result will be sent.
8. **Telephone(s)** Contact person's telephone numbers and extension numbers (if apply)
9. **Cellphone Contact person's cell phone numbers**
10. **Mailing Address** Include additional address where the provider will receive the correspondence.

Section A.3: TYPE OF REQUEST

1. Mark with an "X" the type of request, as applicable. If the following areas was selected, please provide all address in Section A.4:
 - Demographics Changes in contract information
 - Add a New Facility or office
 - Change of Individual to corporation
 - Add a new Specialty.
 - New Group
 - Change of Specialty
 - Exclusion (include letter)
 - Inclusion to Group
 - Add Line of business (LOB)
 - Add Service
 - Change Tax id (include letter)
 - Change NPI (include Old and New NPI)
 - Other:

Section A.4: LINE OF BUSINESS

1. **Which line(s) of business do you want to add to your contract?** Mark with an "X" all lines of business for which the provider wants to be considered (do not mark lines of business for which the provider is already active)
2. **Indicate which line(s) of business you are currently active:** Mark with an "X" all lines of business for which the provider has been already contracted. (Lines of business marked here should not be marked in previous question.)

Section A.5: MAILING ADDRESS

1. Mark with an "X" Mark with an "X" to identify address is: New, Delete or Modify
2. **Mailing Address:** Include the mailing address where the provider has an office or facility.
3. **Cellphone** provider's cellphone numbers
4. **Fax** provider's fax number
5. **Email** Include provider's e-mail address

Section A.6: PHYSICAL ADDRESS

1. Mark with an "X" to identify address is: New, Delete or Modify
2. **Physical Address:** Include the physical address where the provider has an office or facility where medical services are offered.
3. **Accept New Patients? Yes or No**
4. **Handicap Access? Yes or No**
5. **E-prescribing? Yes or No**
6. **Telephone** Include office phone number
7. **Fax** provider's fax number
8. **Email** Include office e-mail address

Section A.7: OFICCE HOURS

1. Provide the hours in each day.

Section B: INDIVIDUAL PROVIDER Section

1. This section is for Individual providers ONLY (Physicians and other Health Care Professionals)
2. Individual Providers **MUST** complete ALL data elements in this section.
3. **Provider Name** Last Names (paternal and maternal), First Name and Middle Name Initial
4. **NPI** Indicate NPI for which the provider wants a contract. If the provider has a Corporation NPI (marked in the previous question), include Provider's individual NPI.
5. **Specialty** Indicate medical specialty.
6. **Medicaid Provider?** Respond YES or NO, as applicable and include Number **Medicaid Management Information System (MMIS)**.

7. **Medicare Provider?** Respond YES or NO, as applicable and include Number **Provider Transaction Access Number (PTAN)**.
8. **Are you a CSP/PSC or CP/PC or CRL/LLC or Other**
 - a. Mark with an "X" the corresponding corporation type where
 - i. CSP/PSC – Corporación de Servicios Profesionales / Professional Service Corporation
 - ii. CP/PC – Corporación Profesional / Professional Corporation
 - iii. CRL/LLC – Corporación de Responsabilidad Limitada / Limited Liability Corporation
 - iv. CORP/INC Corporation incorporated/Corporación/Incorporación
 - b. **Corporation Name** If a Corporation, include Name of Corporation
 - c. **Corporation NPI** Indicate NPI of the corporation
 - d. **Corporation Documents** Included the required documents for the corporation. All the documents must be valid.
 - e. **Provider is part of any Group, IPA or PMG Yes or No if yes, completed Group name and NPI Number.**
 - f. **Provider is PCP Yes or No if yes, completed Group name and NPI Number.**
 - g. Provider is certified by Department of Health for administer sedation or general anesthesia? respond Yes, No or N/A (dentist only)
 - h. Provider certified by Department of Health for Radiation license (X-Ray)? if apply only specialties: Dentist, Chiropractic, Optometry, Podiatry.
 - i. Provider certified in telehealth or telemedicine. Respond Yes or No if yes, include certification.

Section C: NON-INDIVIDUAL PROVIDERS Section

1. This section is for providers who are NOT individuals, such as but not limited to, Imaging Centers, Hospitals, Emergency Room, DME, Ambulatory Chemotherapy or Surgical Centers, Laboratories, etc.
2. If one of the following is marked, the information shown below MUST also be provided:
 - a. **HOSPITAL** List of ALL NPIs of subparts of the facility whose services are wanted to be considered for contracting.
 - b. **CLINICAL LABORATORY** Must respond a YES or NO to the question **Do you have the Clinical Chemistry Equipment for each individual location?**
 - c. **Laboratories: Include evidence of registration to share results.**
 - d. **EMERGENCY ROOM** Must respond a YES or NO to the question **is the facility available 24 hours?**
 - e. **IMAGING CENTER** Mark with an "X" as applicable, the following image types
 - i. **Hi-tech Images** (CT, MRI, PET, Nuclear Medicine)

Other Images Specify what type of images will be rendered.