# StCentralized Verification Office

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# PROVIDER INFORMATION CHANGE FORM

This *is an automated form. To move forward press the “Tab” key or use your mouse to click on the appropriate box or shaded area (ooooo). To move backwards, press “Shift Tab” or point and click with the mouse. To place an “X” in a box, either point and click with the mouse or press the “Spacebar.” To remove an “X”, point and click or press the “Spacebar” again.*

***Please complete and email to:*** [***cvo@slhs.org***](mailto:cvo@slhs.org)

|  |  |  |
| --- | --- | --- |
| ***CHANGE REQUESTED BY*** | | |
| **Facility:**  Elmore  Jerome  Magic Valley  McCall  Treasure Valley  Wood River  Non-Staff Provider | **Person Completing this form:**  **Name:**  **Phone:** | **Today’s Date:** |
| ***PRACTITIONER INFORMATION*** | | |
| **Practitioner (Legal) Name:**    ***If this is a name change it must be accompanied with legal document, ie marriage license, divorce decree, court order, etc)*** | | **Title:**  MD  DO  DPM   DDS  DMD   PA  NP  CRNA  Other: |
| **Clinic Name \*:**    **TIN:** | **Clinic Address:** | **Phone:**  **Fax:** |
| **Cell Phone Number:** | **Home Number:** | **Pager Number:** |
| **Email Address:** | **Service/Exchange Number:** | **Practitioners this change affects (Medical Staff and Allied Health ) \*:** |
| ***\* Office Name and Practitioners it affects is required for address, phone and fax changes*** | | |
| ***ST. LUKE’S CLINICS ONLY*** | | |
| **Accepting New Patients: Referral Required:**  **YES**  **NO**  **YES**  **NO** | | |
| **Do you currently use dashboard to access SL records?**  **YES**  **NO** | | |
| **Change in Clinic organization (division medical director, dyad, triad, site medical manager):** | | |
| **Clinic Manager Name :** | **Clinic Manager Phone:** | **Clinic Manager Email :** |
| ***VERIFICATION OF DATA CHANGE*** | | |
| **I attest that this information has been verified with the provider or the provider’s office:**  **YES**  **NO** | | |
| **NOTES/COMMENTS:** | | |