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|  https://lfweb.corp.medica.com/WebLink/ElectronicFile.aspx?dbid=0&docid=977315  | Clinic or Facility Add/ Term/ Change (ATC) Form ***Revised November 2022*** |

# How to submit the completed ATC form:

Providers who do not have access to the Provider Demographic Update Online Tool\* may submit demographic changes on this form. This is the **only** form that will be accepted to make changes to Medica demographics. This form replaces any and all other previous forms for site add, term, and/or changes for Medica demographics for contracted providers.

This form is in MSWord document format (do not scan or convert this form to pdf). Please use “File, Save As” and rename the form so you will have a full original form to open for your next submission.

* ***Preferred Method:*** E-mail the form to MedicaDemoFormSubmis@medica.com
	+ Please populate the subject line with text similar to:
		- Legal Entity Name – Site Add *(or change or term)* Clinic
		- Legal Entity Name – Site Add *(or change or term)* Facility

***Important Documents to Include with completed ATC Form:***

* *If you are submitting a Legal Entity Name and or Fed ID Change – include a copy of your W-9*
* *If you are submitting a site term - include a copy of the term letter that was sent to patients*
* *If you are a DME or O&P Provider – include a copy of your most current Certification*

***Requested effective date for change:***After submitting an ATC form to Medica, providers should expect related system changes to take effect in 30 to 45 days after receipt. *However, to ensure that a change request for a site addition or termination is completed by the requested effective date, the ATC form should be submitted to Medica 60 days in advance of the requested effective date of the change.*

***Additional practitioners (more than 10):*** *Please use the Additional Practitioner List as needed.*

**\*Provider Demographic Update Online Tool:**

Providers can make demographic updates online using the secure Online Provider Demographics Update Tool located on medica.com under Electronic Transactions: <https://www.medica.com/providers/electronic-transactions>

To enter the electronic tools section, a username and password is required.  If you have not yet registered as a user on medica.com, you will need to create a provider account, including an email address. For more about registering, refer to the [Registration Frequently Asked Questions](https://www.medica.com/providers/electronic-transactions/login-faq).

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| https://lfweb.corp.medica.com/WebLink/ElectronicFile.aspx?dbid=0&docid=977315 | Clinic or Facility Add/ Term/ Change (ATC) Form*Revised November 2022* |
| **ATC Action** | [ ]  **Add** site to existing contract (please answer questions below if adding a site)**Requested Eff Date:**      * Is this an outreach location:
* Show site in directory:
* Is this site for directory purposes only:
 | [ ]  **Term:** If term effective date is within 60 days of this request or a futuristic date you are required to include the closing letter sent to patients**Term Type:** **Term Date:**        | [ ]  **Change:**  **Provider Requested Eff Date for Change:**        |
| **Is this request the result of a Merger/Acquisition?**  | **Old Name:**      **Old Address:**      **Old Tax ID:**       **Old NPI:**        |
| Comments: *(For term or change please explain)* |       |
| Clinic /Facility **Type** | **CLINIC:**   | **Clinic/Specialty Type:**  **A-F:**  **G-N:**  **O-P:**  **R-V:**  |
| **FACILITY:**   | **ANCILLARY:**  | **RAPLET:**  |
| Legal Entity Name:       |
| Clinic / Facility Name:       |
| Directory Name:      *Only fill in this section if different from site name (Max of 100 Characters)* |
| Check Name:       |
| Clinic / Facility Tax ID:      *(Submit a copy of your W-9 for Legal Entity/Check Name and/or Fed ID changes)* | **NPI or UMPI**:      *Include All NPI’s specific to this site* |
| **Medicare Number:**       | **Medicaid Number:**       | **Medicaid State:**    |
| **Clinic / Facility Information***All fields are required* | Street Address and Suite #:       |
| City:       | State:       | Zip:       |
| County:       | Phone:        | Fax:       |
| **Billing Information***All fields are required* | Street Address and Suite #:       |
| City:       | State:       | Zip:       |
| **Provider Website:**       | **Clinic Hours:**      *Include days and hours specific to this site* |
| **Hospital Affiliations *(name and address*):**       |
| **Delegated Provider:** Select One  | **Delegate Name:** Select One |
| **Federally Qualified Health Clinic:** Select One | **Rural Health Clinic:** Select One | **Comprehensive Outpatient Rehab Facility:** Select One |
| **Supply Oxygen?:** Select One | **Bill Type:** Select One  | **Place of Service Code:**        |
| **Does this site comply with the American Disability Act (ADA)?**Select One. | **Does this site have an accessible office?** Select One |
| **Does this site have accessible exam rooms?** Select One | **Does this site have accessible equipment?** Select One |
| **Has the staff in your office completed Cultural Competency Training?** Select One |
| **Do any staff in your office possess the following cultural capabilities? *(select all that apply below)*** |
| **Cultural Awareness:**  [ ]  | **Cultural Safety:** [ ]  | **Cultural Competence:**  [ ]  |

**Form Completed by:** **Phone:** **Date:**

**Email Address:**

**Submit a copy of your W-9 form & a copy of site term letter sent to patients (if applicable, see Note section above) along with this ATC form to:** MedicaDemoFormSubmis@medica.com (or see instruction page for additional options)

**Practitioner List**

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| **Practitioner 1** |
| **SSN** |       | **License Number** |       | **Practicing As** | Select One |
| **NPI** |       | **License State** |    | **Practicing Specialty at this location** | Select One |
| **Practitioner’s Name** |       | **DEA Number** |       | **Directory Suppress?** | Select One |
| **Degree** |       | **DEA State** |    | **Regularly Sees Patients Here at Least Once Per Week? (if no, the address will be suppressed)** | Select One |
| **CAQH ID** |       | **Race &/or Ethnicity** | Select One | **Do you offer Telehealth at this location?** | Select One |
| **Gender** |       | **Display Race &/or Ethnicity in Directory?** | Select One |  **Telehealth Type (if Telehealth is offered)** | Select One |
| **Date of Birth** |       | **Accepting New Patients?** | Select One |  **Telehealth Phone** [ ]  **Telehealth Video** [ ]  **Telehealth Chat** [ ]   |

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| **Practitioner 2** |
| **SSN** |       | **License Number** |       | **Practicing As** | Select One |
| **NPI** |       | **License State** |    | **Practicing Specialty at this location** | Select One |
| **Practitioner’s Name** |       | **DEA Number** |       | **Directory Suppress?** | Select One |
| **Degree** |       | **DEA State** |    | **Regularly Sees Patients Here at Least Once Per Week?** | Select One |
| **CAQH ID** |       | **Race &/or Ethnicity** | Select One | **Do you offer Telehealth at this location?** | Select One |
| **Gender** |       | **Display Race &/or Ethnicity in Directory?** | Select One |  **Telehealth Type (if Telehealth is offered)** | Select One |
| **Date of Birth** |       | **Accepting New Patients?** | Select One |  **Telehealth Phone** [ ]  **Telehealth Video** [ ]  **Telehealth Chat** [ ]   |

**Practitioner List continued**

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| **Practitioner 3** |
| **SSN** |  | **License Number** |       | **Practicing As** | Select One |
| **NPI** |       | **License State** |    | **Practicing Specialty at this location** | Select One |
| **Practitioner’s Name** |       | **DEA Number** |       | **Directory Suppress?** | Select One |
| **Degree** |       | **DEA State** |    | **Regularly Sees Patients Here at Least Once Per Week?** | Select One |
| **CAQH ID** |       | **Race &/or Ethnicity** | Select One | **Do you offer Telehealth at this location?** | Select One |
| **Gender** |       | **Display Race &/or Ethnicity in Directory?** | Select One |  **Telehealth Type (if Telehealth is offered)** | Select One |
| **Date of Birth** |       | **Accepting New Patients?** | Select One |  **Telehealth Phone** [ ]  **Telehealth Video** [ ]  **Telehealth Chat** [ ]   |

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| **Practitioner 4** |
| **SSN** |  | **License Number** |       | **Practicing As** | Select One |
| **NPI** |       | **License State** |       | **Practicing Specialty at this location** | Select One |
| **Practitioner’s Name** |       | **DEA Number** |       | **Directory Suppress?** | Select One |
| **Degree** |       | **DEA State** |       | **Regularly Sees Patients Here at Least Once Per Week?** | Select One |
| **CAQH ID** |       | **Race &/or Ethnicity** | Select One | **Do you offer Telehealth at this location?** | Select One |
| **Gender** |       | **Display Race &/or Ethnicity in Directory?** | Select One |  **Telehealth Type (if Telehealth is offered)** | Select One |
| **Date of Birth** |       | **Accepting New Patients?** | Select One |  **Telehealth Phone** [ ]  **Telehealth Video** [ ]  **Telehealth Chat** [ ]   |

**Practitioner List continued**

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| **Practitioner 5** |
| **SSN** |  | **License Number** |       | **Practicing As** | Select One |
| **NPI** |       | **License State** |  | **Practicing Specialty at this location** | Select One |
| **Practitioner’s Name** |       | **DEA Number** |       | **Directory Suppress?** | Select One |
| **Degree** |       | **DEA State** |    | **Regularly Sees Patients Here at Least Once Per Week?** | Select One |
| **CAQH ID** |       | **Race &/or Ethnicity** | Select One | **Do you offer Telehealth at this location?** | Select One |
| **Gender** |       | **Display Race &/or Ethnicity in Directory?** | Select One |  **Telehealth Type (if Telehealth is offered)** | Select One |
| **Date of Birth** |       | **Accepting New Patients?** | Select One |  **Telehealth Phone** [ ]  **Telehealth Video** [ ]  **Telehealth Chat** [ ]   |

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| **Practitioner 6** |
| **SSN** |  | **License Number** |       | **Practicing As** | Select One |
| **NPI** |       | **License State** |    | **Practicing Specialty at this location** | Select One |
| **Practitioner’s Name** |       | **DEA Number** |       | **Directory Suppress?** | Select One |
| **Degree** |       | **DEA State** |    | **Regularly Sees Patients Here at Least Once Per Week?** | Select One |
| **CAQH ID** |       | **Race &/or Ethnicity** | Select One | **Do you offer Telehealth at this location?** | Select One |
| **Gender** |       | **Display Race &/or Ethnicity in Directory?** | Select One |  **Telehealth Type (if Telehealth is offered)** | Select One |
| **Date of Birth** |       | **Accepting New Patients?** | Select One |  **Telehealth Phone** [ ]  **Telehealth Video** [ ]  **Telehealth Chat** [ ]   |

**Practitioner List continued**

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| **Practitioner 7** |
| **SSN** |  | **License Number** |       | **Practicing As** | Select One |
| **NPI** |       | **License State** |    | **Practicing Specialty at this location** | Select One |
| **Practitioner’s Name** |       | **DEA Number** |       | **Directory Suppress?** | Select One |
| **Degree** |       | **DEA State** |    | **Regularly Sees Patients Here at Least Once Per Week?** | Select One |
| **CAQH ID** |       | **Race &/or Ethnicity** | Select One | **Do you offer Telehealth at this location?** | Select One |
| **Gender** |       | **Display Race &/or Ethnicity in Directory?** | Select One |  **Telehealth Type (if Telehealth is offered)** | Select One |
| **Date of Birth** |       | **Accepting New Patients?** | Select One |  **Telehealth Phone** [ ]  **Telehealth Video** [ ]  **Telehealth Chat** [ ]   |

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| **Practitioner 8** |
| **SSN** |  | **License Number** |       | **Practicing As** | Select One |
| **NPI** |       | **License State** |    | **Practicing Specialty at this location** | Select One |
| **Practitioner’s Name** |       | **DEA Number** |       | **Directory Suppress?** | Select One |
| **Degree** |       | **DEA State** |    | **Regularly Sees Patients Here at Least Once Per Week?** | Select One |
| **CAQH ID** |       | **Race &/or Ethnicity** | Select One | **Do you offer Telehealth at this location?** | Select One |
| **Gender** |       | **Display Race &/or Ethnicity in Directory?** | Select One |  **Telehealth Type (if Telehealth is offered)** | Select One |
| **Date of Birth** |       | **Accepting New Patients?** | Select One |  **Telehealth Phone** [ ]  **Telehealth Video** [ ]  **Telehealth Chat** [ ]   |

**Practitioner List continued**

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| **Practitioner 9** |
| **SSN** |  | **License Number** |       | **Practicing As** | Select One |
| **NPI** |       | **License State** |    | **Practicing Specialty at this location** | Select One |
| **Practitioner’s Name** |       | **DEA Number** |       | **Directory Suppress?** | Select One |
| **Degree** |       | **DEA State** |    | **Regularly Sees Patients Here at Least Once Per Week?** | Select One |
| **CAQH ID** |       | **Race &/or Ethnicity** | Select One | **Do you offer Telehealth at this location?** | Select One |
| **Gender** |       | **Display Race &/or Ethnicity in Directory?** | Select One |  **Telehealth Type (if Telehealth is offered)** | Select One |
| **Date of Birth** |       | **Accepting New Patients?** | Select One |  **Telehealth Phone** [ ]  **Telehealth Video** [ ]  **Telehealth Chat** [ ]   |

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| **Practitioner 10** |
| **SSN** |  | **License Number** |       | **Practicing As** | Select One |
| **NPI** |       | **License State** |    | **Practicing Specialty at this location** | Select One |
| **Practitioner’s Name** |       | **DEA Number** |  | **Directory Suppress?** | Select One |
| **Degree** |       | **DEA State** |    | **Regularly Sees Patients Here at Least Once Per Week?** | Select One |
| **CAQH ID** |       | **Race &/or Ethnicity** | Select One | **Do you offer Telehealth at this location?** | Select One |
| **Gender** |       | **Display Race &/or Ethnicity in Directory?** | Select One |  **Telehealth Type (if Telehealth is offered)** | Select One |
| **Date of Birth** |       | **Accepting New Patients?** | Select One |  **Telehealth Phone** [ ]  **Telehealth Video** [ ]  **Telehealth Chat** [ ]   |