St. Luke's Health Partners

Provider Update Form

BRIGHT PATH

☐ Provider Add/Change Location ☐ Provider Termination ☐ Facility Based Provider Application
☐ Group Add/Change Location ☐ Group Termination

Provider Information

Provider Name and Title		**Race/Ethnicity** ❑American Indian ❑Asian ❑Black or African American ❑Hispanic or Latino ❑ White ❑Native Hawaiian or Pacific Islander ❑Two or More Races ❑Prefer not to disclose	
Social Security No.	**Languages spoken other than English**	**Gender Identity** ❑Male ❑ Non-binary ❑Female ❑Transgender ❑Prefer not to disclose	**Date of Birth**
Individual NPI	**State License # (attach copy)**	**DEA No. (attach copy)**	**PTAN**
Which primary specialty are you practicing at this location?	**Provider Email**	**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 ❑ Term Tax ID Effective Date at Practice Location_____

Location Name		**Location Address: Street, City, State & Zip**	
Entity Legal Name	**Location Phone**	**Location Fax**	**On average, how soon can a new patient get an appointment?** ❑ Within 48 hours ❑ Within 2 weeks ❑ 2-4 weeks ❑ 4-6 weeks ❑ Beyond 6 weeks
Tax ID		**Type 2 Organizational NPI**	
Is your practice handicapped accessible? ❑Yes ❑ No		**Is this your primary practice location?** ❑Yes ❑ No	
Notice Address (if different from billing or location address)		**Billing address (if different than service address)**	
Billing Phone		**Billing Fax**	

If changing locations, indicate what address should be eliminated:

Credentialing Contact	Credentialing Contact email Address

Clinic Hours of Operation for this Location (not provider specific)

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 provide Telehealth services at this location? ❑ Yes ❑ No

Do you practice Urgent Care at this location? ❑ Yes ❑ No

Are you SAMHSA certified for Medication-Assisted Treatment (MAT)? ❑ Yes ❑ No

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

Do you offer Interpretation Services? ❑ Yes ❑ No

Patient Parameter: 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***