



# *Provider Maintenance Form*

A quick and easy new way for Anthem Blue Cross and Blue Shield Medicaid (Anthem) providers to submit demographic updates online

# Submit demographic updates online

The *Provider Maintenance Form (PMF)* is an online form used to request changes to existing practice profiles of Kentucky physicians, practitioners, professionals and ancillary professional providers with Anthem.

It is critical that your patients (our members) receive accurate and current data related to provider services and availability.

We strive to keep accurate and regularly updated provider demographic information in the online provider directory. Keeping accurate health plan directories does require prompt notification from our contracted providers.

One *PMF* submission will ensure updates are made for all lines of business.

# General rules for submitting change request

- The change request should be submitted by the provider, practice manager or a designated person of authority.
- As a general rule, a minimum of 30 day's advance notice of a provider demographic and/or practice change is required. Refer to the requirements in your *Provider Agreement*.
- Certain changes may be assigned a future effective date.
- Contractual guidelines may supersede the requested effective date of requests.
- An updated IRS W-9 form or other documentation that is required for certain changes should be attached to the online form prior to submission.

# Where is the *PMF* located?

Follow the steps below to access the *PMF*:

- Navigate to <https://mediproviders.anthem.com/ky>.
- Select **Provider Forms** on the left of the page.
- Select the **Provider Maintenance Form** then click on the link.



# Where is the *PMF* located on Availity?

The *PMF* is located on the Availity Portal:

- Navigate to **<https://www.Availity.com>**.
- After logging in, select **Payer Spaces**.
- Select the Anthem Blue Cross and Blue Shield Medicaid logo.
- Select **Resources** to access the Provider Maintenance Form.

The screenshot displays the Availity portal interface. The top navigation bar includes links for Home, Notifications (3), My Favorites, Kentucky (circled in red), and Help & Training. Below this, a secondary navigation bar contains My Providers, Reporting, Payer Spaces (circled in red), and More. The main content area features the Anthem BlueCross BlueShield logo and a welcome message for providers. A large image shows a healthcare professional holding a tablet. At the bottom, a tabbed interface shows Applications, Resources (circled in red), and News and Announcements. A disclaimer at the bottom states: "THESE LINKS MAY RE-DIRECT TO THIRD PARTY SITES AND ARE PROVIDED FOR YOUR CONVENIENCE ONLY. AVAILITY IS NOT RESPONSIBLE FOR THE CONTENT OR SECURITY OF ANY THIRD PARTY SITES AND DOES NOT ENDORSE ANY PRODUCTS OR SERVICES PROVIDED BY THIRD PARTIES!"



# Individual vs. Organization

## Provider Maintenance Form

The Provider Maintenance Form (PMF) is used to request changes to existing practice profiles of California physicians, practitioners, professionals and ancillary providers with Anthem Blue Cross.

First time users should view all Informational Tool Tips ⓘ to ensure the form is submitted accurately.

Change requests should be submitted by the practice manager or a designated person of authority.

**As a general rule, a minimum of 30 days advance notice of a provider demographic and/or practice change is required. Refer to the requirements in your Provider Agreement.**

Certain changes may be assigned a future effective date.

Contractual guidelines may supersede the requested effective date of requests.

For change(s) that require submission of an updated IRS Form, W9, or other documentation, attach them to the form in-line prior to submitting.

| Please select either Individual or Organization                                                        |              |
|--------------------------------------------------------------------------------------------------------|--------------|
| <b>Individual</b>                                                                                      | Organization |
| <i>An Individual is a unique healthcare provider who serves patients in one or many organizations.</i> |              |
| ✦ Individual Change Type Descriptions                                                                  |              |

An individual is a unique health care provider who serves patients in one or many organizations.

Use this to make a change for a person's record.

An organization is a location, company or group of providers that deliver(s) health care through one or many providers.

Use this to make a change for a location or a provider group.

# Changes for individual providers

Personal profile updates for individuals:

- **Accepting New Patients**
- **Address - Add Location**
- **Address - Terminate**
- **Email Address**
- **Handicapped Accessibility**
- **Languages Spoken**
- **National Provider Identifier (NPI)**
- **Office Hours / Days of Operation**
- **Office Hours / Days of Operation**
- **Patient Age / Gender Preference**
- **Phone / Fax Number**
- **Provider Specialty**
- **Provider or Address Terminate**
- **Termination of Provider Participation Agreement**
- **Update Provider Name**

# Changes for organizations

Changes for an entire organization (group practice or company-level updates):

- **Accepting New Patients**
- **Address - Add Location**
- **Address - Terminate**
- **Email Address**
- **Handicapped Accessibility**
- **Languages Spoken**
- **National Provider Identifier (NPI)**
- **Office Hours / Days of Operation**
- **Phone / Fax Number**
- **Provider Leaving Group**
- **Remove Provider From Location**
- **Roster or List Updates**
- **Termination of Provider Participation Agreement**
- **Update Organization Name**
- **Web Address**



# Some changes are simply a request for action

- Changing an individual provider specialty may require credentialing.
- Each change request is subject to review and approval by a contract manager.
- Some change request may require additional contracting.
- These change requests are not considered a guarantee of participation or notice of termination.
- Always refer to the change request or termination clause in your *Provider Agreement* for additional requirements.

# Completing the form

Navigate to the *General Information* tab.

The screenshot shows the 'General Information' tab of a form. At the top, there are four tabs: 'General Information' (selected), 'Select Updates', 'Specify Change Details', and 'Confirmation'. Below the tabs, there is a message: 'Changes for multiple providers must be submitted separately.' and a link '< Back to Landing Page'. The form is divided into several sections:

- Individual Provider Details**:
  - Effective Date**: A date field with the value '07/26/2017' and a calendar icon. A note below says 'Commercial policies may supersede effective date request.'
  - Networks**: A section with the question 'Which networks will this update affect?'. There are three checkboxes: 'Commercial' (checked), 'Medicare' (checked), and 'Medicaid' (checked).
  - Provider Details**: Fields for '123456789', '0001654321', 'Smith' (with a dropdown arrow), 'John' (with a dropdown arrow), 'MD' (with a dropdown arrow), and 'CA1234'.
  - Practice Office Location**: Fields for '123 Ivy Drive', 'Suite B', 'Santa Barbara' (with a dropdown arrow), 'California' (with a dropdown arrow), '93101', and 'Santa Barbara'.
  - Contact Information**: Fields for 'Who is filling out this form?', 'Jane' (with a dropdown arrow), 'Doe', 'jdoe@gmail.com', and '(555) 123-4567'.

At the bottom of the form, there are two buttons: 'CANCEL' (with a link 'Return to Landing Page') and 'NEXT'.

Effective Date is the requested date an update will take effect. Providing advance notice of a change will help to ensure a timely update. Some changes cannot be made for retroactive dates and will be dated the same as the received date.

All change options selected will apply to the person or organization entered in the name field at the location entered in the address field.

## Important note:

Provider details and location details should reflect the current information on our records. The NEW or updated information should be entered later in the form. If the change has occurred in the past, enter the previous information here (e.g., moved, tax ID or name changed, etc.).

# SELECT UPDATES

Select the appropriate tile or tiles for the change request.

Select one or many.



Select all items you would like to update.

NOTE: Changes for multiple providers must be submitted separately.

[< Back to General Information Page](#)

|                                               |                                                 |
|-----------------------------------------------|-------------------------------------------------|
| Accepting New Patients                        | Office Hours / Days of Operation                |
| Address - Add Location                        | Patient Age / Gender Preference ✓               |
| Areas of Expertise (Behavioral Health Only)   | Phone / Fax Number                              |
| Handicapped Accessibility                     | Provider Specialty                              |
| Hospital Affiliation and Admitting Privileges | Provider or Address Terminate                   |
| Languages Spoken                              | Termination of Provider Participation Agreement |
| License / Certification Number                | Update Provider Name ✓                          |
| National Provider Identifier (NPI)            |                                                 |

Next

4 items selected

The progression arrow at the top of the page displays the progress of the completed form.

When making various changes for various providers, submit each person's update separately under the individual tab. If making a change applicable to all providers at a location, select organization.

Select tiles pertaining to the required updates (one or more). Only select a tile if an update or change is needed. You may de-select by clicking the tile again.

# COMPLETE DETAILS FOR CHANGE OPTIONS SELECTED

The screenshot shows a web form titled 'Specify Change Details' with a progress bar at the top indicating the current step. On the left is a sidebar with patient information: Name (John Smith I), NPI (0987654321), TIN (#####6789), Address (123 Ivy Drive, Suite C, Santa Barbara, California 93101), and Change Effective Date (05/01/2018). The main content area has two sections: 'Languages Spoken' and 'Provider Specialty'. In the 'Languages Spoken' section, a red arrow points to the 'Add' button. In the 'Provider Specialty' section, a red arrow points to the 'Add' button in the 'Additional Specialty' subsection.

General Information | Select Updates | **Specify Change Details** | Confirmation

Add details for selected updates. \* Indicates a Required Field [< Back to Select Updates Page](#)

**Name**  
John Smith I

**NPI**  
0987654321

**TIN**  
#####6789

**Address**  
123 Ivy Drive, Suite C, Santa Barbara, California 93101

**Change Effective Date**  
05/01/2018

**Languages Spoken**

Language Spoken  
Select One

Add Another Language

**Provider Specialty**

What type of specialty request is this?

Are you acting as a Primary Care Physician at this location?

☒ Primary Specialty  
Select One

Additional Specialty  
Select One

Add Additional Specialty

Enter your change details for the selected options

Remember to provide updates when deleting the previous/old information from the record as applicable.

When adding new detail, such as language spoken or hospital privileges, select the **Add** to expand additional entry fields.

# ATTACHMENTS

■ Attachments

Please upload documentation to support the information entered on this form. You will be allowed to attach MS Word, MS Excel, 'jpg', 'pdf', 'gif', 'txt' or 'csv' file types. There is a combined limit of 10 MB for all attachments.

Choose File:

Choose File

No file chosen

Description of Attachment:

Upload File:

Upload File

| File Name | Size | Description |
|-----------|------|-------------|
|-----------|------|-------------|

Attach any necessary documentation to support the request (e.g., W-9 for Tax ID changes, copy of updated license for name changes, etc.)



The Attachment limit is 10MB, however, a zipped file can be attached to decrease the size if necessary.

# FINAL REVIEW OF THE SUBMISSION

Provider Maintenance Form

General Information   Select Updates   Specify Change Details   **Review and Attest**

### Review for Submission

General Information  

All changes made on this form will apply to the information entered in the General Information.


**Effective Date**  
Date: 07/26/2017

**Networks**  
Network: Commercial  
Network: Medicare

**Provider Details**  
Tax Identification Number: 123456789  
National Provider Identifier: 0987654321  
Name: John Smith  
Suffix: I  
Title: MD  
License / Certification Number: 1234

**Practice Office Location**  
Address: 123 Ivy Drive  
Address Line 2: Suite B  
City: Santa Barbara  
State: California  
Zip Code: 93191  
County: Santa Barbara

**Contact Information**  
First Name: Jane  
Last Name: Doe  
Email: Doctorsoffice@aol.com  
Phone Number: (888) 555-4444

**Specified Change Details** 

**Accepting New Patients**  
Accepting New Patient: Yes  
Minimum Age: 0  
Maximum Age: 100  
Gender Preference: Both

**Office Hours / Days of Operation**  
Day: Monday   Open: 8:00 AM   Close: 5:00 PM  
Day: Tuesday   Open: 8:00 AM   Close: 5:00 PM  
Day: Wednesday   Open: Closed   Close: Closed  
Day: Thursday   Open: 8:00 AM   Close: 5:00 PM  
Day: Friday   Open: 10:00 AM   Close: 7:00 PM  
Day: Saturday   Open: Closed   Close: Closed  
Day: Sunday   Open: Closed   Close: Closed

**Phone / Fax Number**  
Add/Delete: Add  
Directory Phone Number: (888) 666-4444  
Add/Delete: Delete  
Directory Phone Number: (888) 444-5555

**Attest**

After completing all necessary fields, review your submission page carefully to ensure accuracy.

You may print this page by selecting the print icon at the top of the page.

You may edit the General Information or Submission Details by selecting the pencil/edit icon.



# ATTEST AND SUBMIT

Attest that the entries are true and correct by checking the box.

- ☒ By clicking "SUBMIT", I hereby request the above changes and certify that the information provided is true and correct. I certify that I am the named professional or am otherwise authorized to make this request on behalf of the named professional.

To avoid processing delays, please review this form before submitting to ensure that all required areas have been completed. Please attach all supporting documentation using the Attachments section.

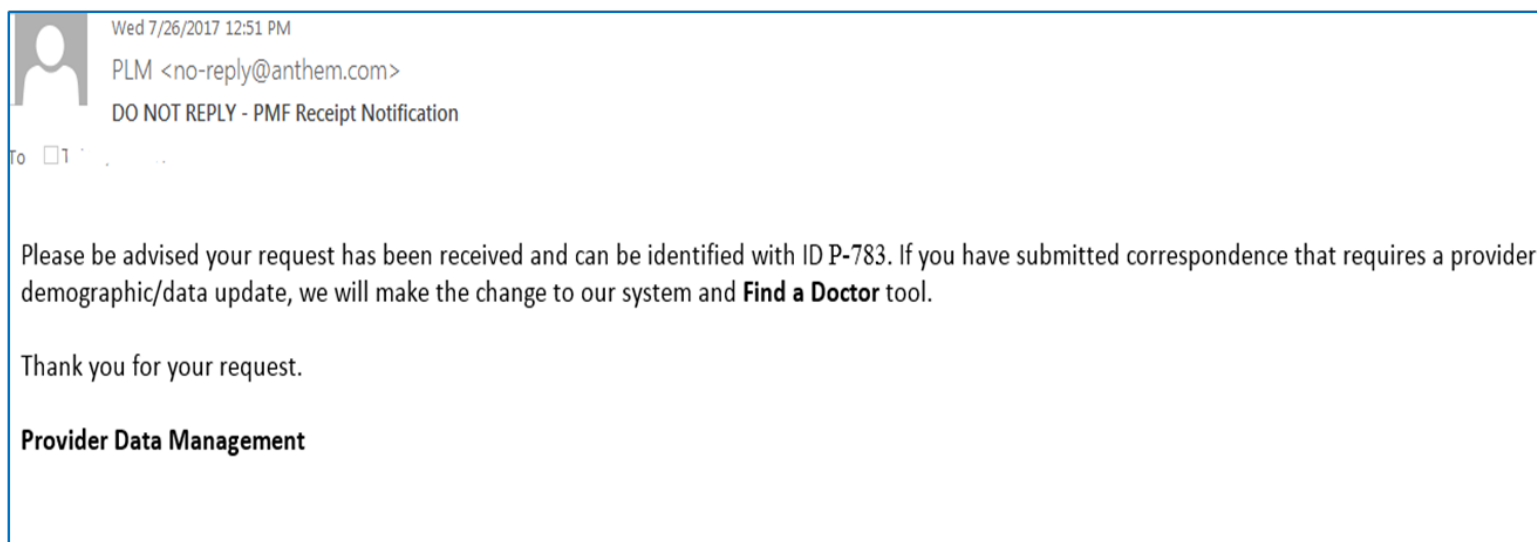
Submit

Select the Submit button.

# Congratulations – Submission sent!

After submission, an email with the change request reference number (P#) will be sent to the address provided in the Contact Information on the *General Information* page.

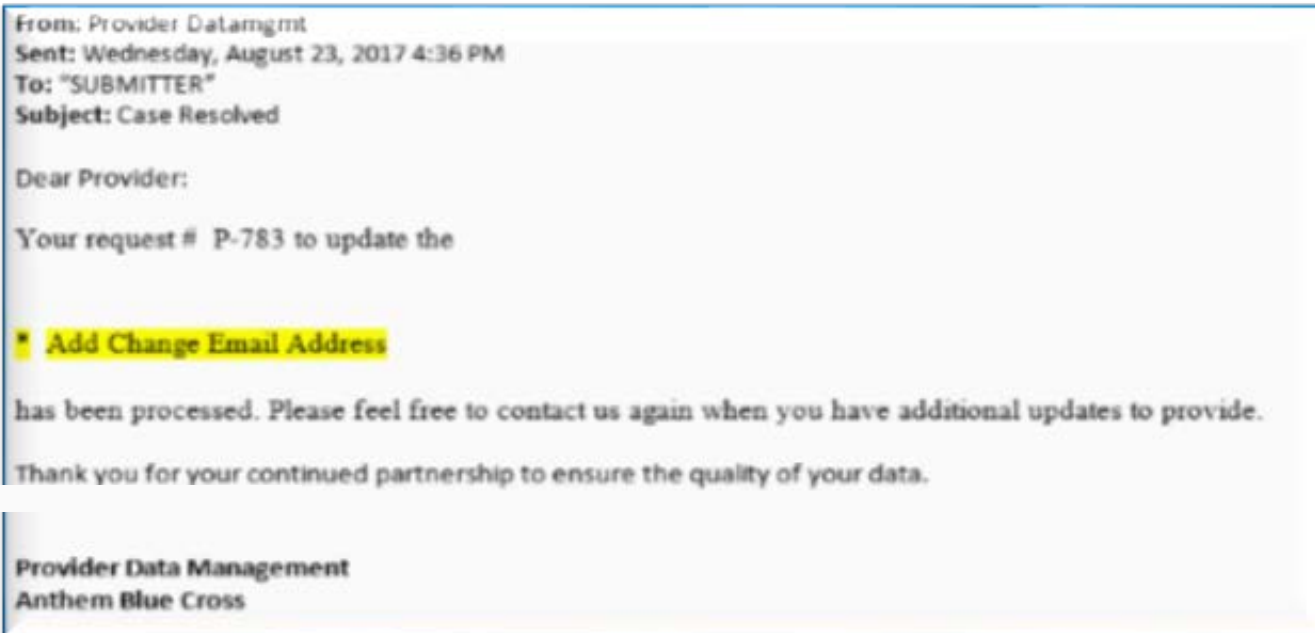
*Please make note of this reference number should there be a need to contact us regarding this request.*



# Notice of completion

A final email message will be sent to the contact email address notifying you when the update has been completed.

*Take precautions to ensure these notifications don't get caught in your SPAM/Junk email bucket.*



# Tips

**When making a change, ensure the information currently on record is entered in *General Information* and the new information is entered in the selected change option form fields. (ie previous address in general information, new address in change option form fields.)**

The screenshot shows a web form titled 'Specify Change Details' with three tabs: 'General Information', 'Select Updates', and 'Specify Change Details'. The 'Specify Change Details' tab is active. The form is divided into two main sections. On the left is a gray sidebar titled 'Add details for selected updates. \* Indicates a Required Field'. It contains fields for Name (Carl Jones), NPI (999999999), TIN (#####7777), Address (7700 S Broadway, Suite #190, Littleton, Kentucky 80122-2602), and Change Effective Date (8/28/2018). A red circle highlights this sidebar. The main form area has a header 'Provider or Address Terminate'. Below it are fields for Termination Date (10/01/2018), Address type (Practice Location), Reason (Provider Address Change), and a question 'Were you acting as a Primary Care Physician at this location?' with 'Yes' and 'No' buttons. At the bottom is an 'Address Details' section with fields for Address, Address Line 2, City, State, Zip Code, and County. A red circle highlights this section. At the very bottom is an 'Attachments' section with a plus icon.

| Field                 | Value                                                       |
|-----------------------|-------------------------------------------------------------|
| Name                  | Carl Jones                                                  |
| NPI                   | 999999999                                                   |
| TIN                   | #####7777                                                   |
| Address               | 7700 S Broadway, Suite #190, Littleton, Kentucky 80122-2602 |
| Change Effective Date | 8/28/2018                                                   |

Termination Date: 10/01/2018

Address type: Practice Location

Reason: Provider Address Change

Were you acting as a Primary Care Physician at this location? Yes No

Address Details

| Field          | Value           |
|----------------|-----------------|
| Address        | 7700 S Broadway |
| Address Line 2 | Suite #190      |
| City           | Littleton       |
| State          | Kentucky        |
| Zip Code       | 80122-2602      |
| County         | Jefferson       |

Throughout the form, the data entered on the *General Information* page is reflected in the left gray column.

All change options selected will apply to the person/organization entered in the name field at the location entered in the address field.

Select the **Edit** pencil icon to return to the *General Information* if changes need to be made there. This information may pre-populate in some change selections.

To remove selected change options or to edit data entered, select *Back to Selected Updates Page* and click the option tile again. Data entered in remaining selected options will remain.

# ADDITIONAL FORM FUNCTIONS

Many selections offer a quick search function in the drop-down choices. Start typing to narrow the search.

Some fields will auto-populate with previously entered information to ensure accuracy.

Office Hours / Days of Operation

Days and Hours of Operation will apply to the address entered in General Information.

|           |          |         |
|-----------|----------|---------|
| Monday    | 8:00 AM  | Closed  |
| Tuesday   | 8:00 AM  | 5:00 AM |
| Wednesday | Closed   | 5:30 AM |
| Thursday  | 8:00 AM  | 5:00 PM |
| Friday    | 10:00 AM | 5:30 PM |
| Saturday  | Closed   | 7:00 PM |
| Sunday    | Closed   | Closed  |

Add details for selected updates. \* Indicates a Required Field

Name  
John Smith I

NPI  
0987654321

TIN  
#####6789

Address  
123 Ivy Drive, Suite B, Santa Barbara, California 93191

Change Effective Date  
07/26/2017

Address - Terminate

Termination Date \*  
mm/dd/yyyy

Address type  
Select One

Reason  
Select One

Address Details

Address: 123 Ivy Drive  
Address Line 2: Suite B  
City: Santa Barbara  
State: California  
Zip Code: 93191  
County: Santa Barbara

# ADDITIONAL FORM FUNCTIONS

Many selections offer a quick search function in the drop-down choices. Start typing to narrow the search.

Office Hours / Days of Operation

Days and Hours of Operation will apply to the address entered in General Information.

|           |          |         |
|-----------|----------|---------|
| Monday    | 8:00 AM  | Closed  |
| Tuesday   | 8:00 AM  | 5:00 AM |
| Wednesday | Closed   | 5:30 AM |
| Thursday  | 8:00 AM  | 5:00 PM |
| Friday    | 10:00 AM | 7:00 PM |
| Saturday  | Closed   | Closed  |
| Sunday    | Closed   | Closed  |

Some fields will auto-populate with previously entered information to ensure accuracy.

Add details for selected updates. \* Indicates a Required Field

Name  
John Smith I

NPI  
0987654321

TIN  
#####700

Address  
123 Ivy Drive, Suite B, Santa Barbara, California 93191

Change Effective Date  
07/26/2017

Address - Terminate

Termination Date \*  
mm/dd/yyyy

Address type  
Select One

Reason  
Select One

Address Details

Address: 123 Ivy Drive  
Address Line 2: Suite B  
City: Santa Barbara  
State: California  
Zip Code: 93191  
County: Santa Barbara



# TROUBLESHOOTING TIPS for the ONLINE PMF

**When working with the Provider Maintenance Form, you may run into technical issues or questions in relation to the form itself. These quick tips will help you navigate this new platform by addressing some of the commonly asked questions about Anthem's improved PMF.**

## **A blank page appears where the change tile selection page should appear**

- Try using the Google Chrome Browser—Anthem's preferred browser for all of the web site material
- Try accessing and completing the form from a different server or smart phone
- Ensure your settings do not restrict pop ups or downloads from this site.

## **Cannot get to the next page, the 'Next' button is greyed out**

- Be sure that the orange colored required fields are populated. If these required fields are not populated, the form will not allow you to proceed to the next page.
- The field name is inside of the field. Once an entry is typed in the field name disappears. Carefully review the form to ensure each required field is populated.
- Watch for red messages that will pop up near the field that needs attention. Though not always easy to detect, if a space is entered at the beginning of an entry, the entry will be invalid. When using "copy/paste" to populate fields, ensure the entry didn't create a space.
- Try typing the entry rather than using the copy/paste function.

# TROUBLESHOOTING TIPS

**A red message appears stating “*You have requested to update a record that requires supporting documentation. Please upload documents using the Attachments section above.*”**

There are 2 change submission types that require supporting documentation. When requesting to change or update to the below items you will need to include a W-9 to substantiate the change:

- Organization Name
- Organization Address—Add Location (specifically when changing the remittance address)

**A red message appears stating “*System unavailable, please try again later*” after selecting the Submit button**

Do not let the form “idle” for long periods of time. Prepare to complete the form through submission after initiation.

Ensure the attachment or combined attachments are less than 10MB. You can zip the file(s) you would like to attach in order to decrease its overall size.

The file type must also be one of these acceptable file types: MS Word, MS Excel, 'jpg', 'pdf', 'gif', 'txt' or 'csv' .

Ensure you have entered appropriate information in the appropriate fields. For example, the email address will hold up to 70 characters. Do not try to type various messages into the form fields. Never use the back button on your web browser, but instead use the back button located at the bottom of the Provider Maintenance Form.

# Thank you

**<https://mediproviders.anthem.com/ky>**

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