Provider Action Request (PAR)

Please check the appropriate box that is applicable.

☐ Sagamore updates ☐ IHN updates

·This form is required to ensure appropriate and authorized modifications to existing Sagamore or IHN provider records.
•Please complete a separate form for each Tax ID Number & Provider

Section I. Current Information

Tax ID Number	Group/Practice Name

Please identify any Physician Hospital Organizations (PHO) or other contracting entities whom you are affiliated : _____ **Please ensure you are notifying these contracting entities of your changes.

Section II. Provider Demographics *required field

*Provider First Name	*MI	* Last Name	*Title (MD/PHD/etc.)

*Specialty

Section III. Reason For Submitting PAR Form - Please Complete All Applicable Sections

ADD	CHANGE	DELETE
**Effective Date of Addition:	**Effective Date of Change:	**Effective Date of Deletion:
To Add a Provider: *For Sagamore please call Provider Services at 1-800-364-3469 or access www.sagamorehn.com. For IHN please contact IHN Provider Services at 1-888-446-6670 or e-mail ihn.provider.relations@ihnppo.com to determine if a new contract is needed.*	☐ **Existing Practice Address or Telephone Number** *Complete Sections IV & V*	☐ **Provider** ☐ *Retired / No Longer Practicing* ☐ *Moved out of state* ☐ *Deceased* ☐ *Left Group* ☐ *Other:* _____
☐ **Location/Address** *Complete Section V* *If more than one new location to be added, also complete Section VI – Additional NEW Locations	☐ **Billing Name, Address or Telephone Number** *Complete sections IV,V* Billing address must match info submitted on claim to ensure claim will be repriced	☐ **Location/Address** *Complete Section IV*
☐ **Specialty** *Additional Specialty:* _____ Must include copy of Board Certificate for this specialty	☐ **Tax ID** *New W-9 Form required for all Tax ID changes* *Old Tax ID:* _____ *Date no longer utilized:* _____ *New Tax ID:* _____ **FYI – Due to various ways a provider may be contracted, changing a TIN may require a new or additional contract. Please call Sagamore Provider Services at 1-800-364-3469 or IHN Provider Services at 1-888-446-6670 to determine if a contract is required.	☐ **Other:** _____ _____
☐ **Additional Tax ID to Provider who is already in Sagamore or IHN Network** *W-9 with new Tax ID Number must be submitted with this form* *Existing TIN:* _____ *NEW TIN to be added:* _____ **FYI – Due to various ways a provider may be contracted, adding a TIN may require a new or additional contract. Please call Sagamore Provider Services at 1-800-364-3469 or IHN Provider Services at 1-888-446-6670 to determine if a contract is required.		**NOTE: Sagamore Health Network and IHN are contractually unable to backdate the effective date of any modifications. ADVANCED NOTICE is required.

Provider Action Request

Section III. Reason For Submitting PAR Form - Continued - Please Complete All Applicable Sections

☐ **Ambassador Care to existing Provider (PCP)**

Ambassador Care Addendum is required.
Call Provider Services at 1-800-364-3469.

☐ **Practice Name**
New W-9 required
Old Name: _____
New Name: _____

☐ **Other:** _____

_____

☐ **Other:** _____

_____

Section IV. OLD Address *required field (If changing or deleting an address, please provide old addresses here)

*Practice Name	*Billing Name
*Practice Address	*Billing Address
*City *State *Zip	*City *State *Zip
*County *Phone Number (___) ___-_____	*County *Billing Phone Number (___) ___-_____
Address to remain active? ☐ Y ☐ N **If no, date no longer utilized:** _____	**Address to remain active? ☐ Y ☐ N** **If no, date no longer utilized:** _____

Section V. NEW Address *required field (To change address or add new location, provide new addresses here)

*Practice Name	*Billing Name
*Practice Address	*Billing Address
*City *State *Zip	*City *State *Zip
*County *Phone Number (___) ___-_____	*County *Billing Phone Number (___) ___-_____

Section VI. Additional NEW Office Location(s) *required field

Please Photocopy If Necessary, And Provide Information For Every Additional Office Location.

*Practice Name	*Billing Name
*Practice Address	*Billing Address
*City *State *Zip	*City *State *Zip
*County *Phone Number (___) ___-_____	*County *Billing Phone Number (___) ___-_____

Section VII. Comments/Other

Provider Action Request

Section VIII. Authorized Signature I hereby verify that the information provided on this form is true and accurate, and I have the authority to request such changes.		
Office Manager (or authorized individual from practice/billing office) Signature	Office Manager (or authorized individual from practice/billing office) Print Name Here	
Phone Number (____) _____ - _____	Fax Number (____) _____ - _____	Date

Note: Incomplete forms may be returned for additional information, and may delay the effective date of such change, as Sagamore or IHN are contractually required to provide ADVANCE NOTICE of changes to all payers. Advance notice of changes enables claims handling.

Please fax the completed form to (317) 573-6638 or mail to: **Sagamore Health Network, Inc.**
Attn: Member & Provider Eligibility
11595 North Meridian Street, Ste. 600
Carmel, IN 46032

or

IHN, Inc
Attn: Member & Provider Eligibility
11595 North Meridian Street, Ste. 600
Carmel, IN 46032

***If submitting this form along with a contract you must mail in this form and the original contract.**

Print Form