CREDENTIALING CHANGE FORM

Please select all entities to which this memo applies:

☐	HOSPITALS	☐	MEDICAL GROUP, INC.

DATE: _____

TO: Credentialing Verification Office

FROM: _____

SUBJECT: Credentialing Change Form

_____ has had a change effective _____

Provider Name **Date**

(Please check appropriate reason)

- ☐ Staff member has retired and no longer requests Privileges.
- ☐ Verbal resignation from the medical staff member has been made to the department chairperson.
- ☐ Failure to submit reappointment application by deadline.
- ☐ Staff member has changed departments. New Department: _____
- ☐ New Hire – Discontinue processing of application.
- ☐ Change in Employment Status/Or Entry Point. Will this change require billing entity to change? Choose One
- ☐ Current Employer/Entry Point Choose One New Employer/Entry Point Choose One
- ☐ Name Change: _____
- ☐ Other: _____

_____ _____

Signature of Clinical Service Chief or Entity Representative **Date**

Note: If this change will impact the practice locations for the provider please remember to complete a Provider Enrollment Change Form and submit it to providerdirectory@unmmg.org
Form is located at: **https://unmhealth.org/clinical-affairs/_files/pe-change-form-updated-09.18.2023.pdf**

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