Please fax the completed form to 866-612-7795 to process

BEACON HEALTH STRATEGIES

NETWORK DEVELOPMENT & CONTRACTING

Provider Amendment Request Form

Group/Facility/Provider Name:	
Date of Request:	
BHS Provider ID#:	
Tax Identification Number (TIN):	
Practice Address-Street/City:	
Practice Address-State:	
Phone Number:	
Fax Number:	
Email:	
Licensure(s) of all providers:	

Please be specific as to what change you are requesting. List each service name, procedure code and modifier(s) you are requesting to be reviewed. Your completed form will be forwarded to the Contract Department for review. You will be contacted by Contract Department staff if we have additional questions. Incomplete forms will be returned.

Service Description	Procedure Code	Modifier