10.0 Quality & Health Management

10.1 Quality & Health Management Program

The KPMAS Quality of Care and Service Program (the “Program”) applies to the patient care delivery system of KPMAS. The Program addresses all medical, behavioral health and service activities provided to internal and external customers, participating practitioners, participating providers and enrollees. All KPMAS Participating Providers and staff are involved in this process, with key staff serving on Quality of Care and Service Program Committees. Members and Participating Providers may request information about the Program including a report of our progress toward quality improvement goals by calling or writing the Member Services Department at:

Kaiser Permanente
Member Services Unit
2101 East Jefferson Street
Rockville, MD 20852

Inside the Local Calling Area: ☏ (301) 468-6000
Toll free Outside the Local Calling Area: ☏ 1 (800) 777-7902
TDD for the Hearing Impaired: ☏ (301) 816-6344

The activities monitored and reviewed by the Quality of Care and Service Program includes, but is not limited to, the following:

- Monitoring access and member satisfaction
- Development and measurement of compliance with clinical practice guidelines and standards of care
- Focused studies of preventive and chronic care
- Identification of individual adverse outcomes and risk events
- Peer Review
- Incorporation of recommendations from external review bodies including the National Committee for Quality Assurance (NCQA) and KPMAS’s Health Plan Quality Oversight (HPQO)

In addition, the Quality of Care and Service Program establishes effective monitoring and evaluation of care and services to ensure the care and service that KPMAS offers its customers meets or exceeds accepted national standards. The Program accomplishes this by:

1. Developing mechanisms to identify, monitor, evaluate and improve important aspects of care and service, including high-volume, high-risk services, by:
   - Ensuring that information from monitoring and evaluation activities is disseminated and used to improve quality of care and service in inpatient, ambulatory, and affiliated settings:
   - Supporting the development and use of evidence-based clinical practice guidelines and formulating implementation plans and outcomes monitoring;
   - Ensuring full qualifications and competence of health care professionals through adherence to KPMAS’s credentialing and recredentialing standards;
   - Assuring compliance with accreditation and regulatory standards;
   - Monitoring access standards and evaluating KPMAS’s compliance with these standards;
   - Providing appropriate oversight of delegated functions and monitoring delegate’s performance against pre-established standards.
2. Providing consistent and timely identification and analysis of opportunities for improvement and intervene to improve care, where appropriate, by:
   • Evaluating the continuity and coordination of care provided to KPMAS members;
   • Promoting member satisfaction and improvements in the health status of members;
   • Viewing complaints about care or service as opportunities for improvement;
   • Providing periodic feedback to members and practitioners regarding measurement and outcomes of quality improvement activities.

3. Improving the health status of KPMAS members whenever possible by:
   • Continually integrating evidence-based clinical standards into quality programs and including these in the development of benchmarks;
   • Surveying members periodically about their perceived health status;
   • Promoting effective health management and case management for members identified with chronic diseases;
   • Encouraging all members to utilize appropriate preventive health services in order to promote member wellness;
   • Identifying and reducing access barriers for any segment of the member population.

4. Continuing to be a recognized leader in local, state and national efforts to promote quality healthcare for all populations, within and outside KPMAS, by:
   • Collaborating with public and private health agencies in quality improvement activities;
   • Demonstrating value to purchasers through outcome-oriented quality assurance and clinical quality improvement activities;
   • Aligning the Program with well-recognized evidence-based clinical goals.

5. Continuing to develop and implement the people strategy by increasing KPMAS employee engagement and satisfaction, attracting diverse and highly talented physicians and staff, fostering a learning environment, and ensuring continuity of organizational knowledge and culture that supports the mission, vision and values of KPMAS by:
   • Creating meaningful practices that reward the organization, physicians, staff and our members.
   • Demonstrating that we respect and value our work force by:
     • Developing their competencies and rewarding their accomplishments
     • Collaborating with each individual and team in order to develop clear, targeted, and measurable expectations
     • Ensuring that highly achieving, talented, committed physicians and staff remain with the organization.

10.2 Clinical Practice Guidelines
Clinical practice guidelines are systematically designed tools to assist participating practitioners and patient decisions regarding specific medical conditions and preventive care. Guidelines are informational and are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by participating practitioners in any particular set of circumstances for each patient.

KPMAS has adopted and implemented the evidence-based Clinical Practice Guidelines developed by the Care Management Institute in conjunction with Permanente physician-experts from across the KP program. These guidelines cover preventive, acute, and chronic care. Preventive care guidelines include, but not limited to, Prenatal Care, Preventive Care for all
Clinical practice guidelines are available to Kaiser Permanente Participating Providers at www.providers.kaiserpermanente.org/mas under Provider Information and Clinical Library or by contacting the Quality Department at 301-816-5763.

10.3 Contracted Provider Participation
Participating Providers are required through their Kaiser Permanente contract to comply with the KPMAS Quality Improvement Program. MAPMG and Participating Providers agree to provide KPMAS with access to medical records, participate in QI program activities and allow the use of performance data. Participating Providers are given regular updates on the status of health plan activities through the Permanente Journal, the Permanente Post, Network News, and other practitioner mailings.

KPMAS encourages Participating Providers to participate in the QI program through membership and participation in Quality Improvement Committees. Participating Providers are also encouraged to provide feedback to QM staff through response to newsletter topics and through practitioner satisfaction surveys.

KPMAS provides ongoing educational services to Participating Providers through new Provider orientation materials, Provider Manual updates, Provider meetings and Provider training by provider education staff.

10.4 Access and Availability Standards
KPMAS has established standards for availability of Participating Providers. These performance standards are reviewed no less than annually. KPMAS has established mechanisms to incorporate ongoing review of both availability and performance measures. This process for measurement of Participating Provider availability identifies opportunities for improvement and implementation of appropriate interventions to ensure Participating Provider availability to the KPMAS membership.

10.5 Credentialing & Re-credentialing Process
The credentialing process is designed to ensure that all licensed independent practitioners and allied health practitioners under contract with MAPMG are qualified, appropriately educated, trained, and competent. All Participating Practitioners must be able to deliver health care according to KPMAS standards of care and all appropriate state and federal regulatory agency guidelines to ensure high quality of care and patient safety. The credentialing process follows applicable accreditation agency guidelines, such as those set forth by the NCQA and KPMAS. KPMAS Participating Providers must meet MAPMG credentialing requirements. KPMAS credentialing policies and procedures are intended to protect our members and ensure quality. The Mid-Atlantic States Credentialing and Privileging Committee (MASCAP), chaired by MAPMG’s Regional Medical Director for Legal Affairs, Risk Management and Patient Safety and Health Plan’s Vice President of Quality and Resource Management, oversees all credentialing and re-credentialing activities.
Initial credentialing and re-credentialing are part of the practitioner/provider contract process. No Participating Provider may see KPMAS members prior to being approved through the credentialing process. All physicians who cover for network providers must be credentialed by MAPMG. Providers will be credentialed upon initial application to the KPMAS provider network; re-credentialing occurs every three years thereafter except for those with KP ambulatory surgery and moderate sedation privileges for whom re-credentialing occurs every two years. All Participating Providers must satisfactorily complete the re-credentialing process to maintain an active status. This process is described in detail below in Section 10.7. Practitioners will be notified within sixty (60) calendar days in writing of the actions taken to approve or disapprove the applicant for participation with KPMAS.

**Provider Responsibilities**
Provider responsibilities in the credentialing process include:

- Submission of a completed application and all required documentation before a contract is signed
- Producing accurate and timely information to ensure proper evaluation of the credentialing application
- Provision of updates or changes to their application within 30 days
- Provision of a current certificate of insurance when initiating a credentialing application. A certificate of insurance must also be submitted at annual renewal.
- Cooperation with site visit and medical record-keeping review process

**Provider Rights**
Provider rights in the credentialing process include:

- Be provided a copy of the MASCAP policies and procedures upon written request
- Reviewing the information contained in his or her credentials file
- Correcting erroneous information contained in his or her credentials file
- Being informed, upon request, of the status of their application
- Appealing decisions of the Credentialing Committee if he/she has been denied re-credentialing, has had their participating status changed, been placed under a performance improvement plan, or had any adverse action taken against them.

These rights may be exercised by contacting the Practitioner and Provider Quality Assurance Department (PPQA) at ☎ (301) 816-5853 or by fax at (301) 816-7133. Written correspondence may also be sent to:

Kaiser Permanente
Practitioner and Provider Quality Assurance- 6 West
2101 East Jefferson Street
Rockville, MD 20852

**Credentialing Files**
- Credentialing files remain confidential according to KPMAS policies and procedures
- Credentialing files are acted upon according to KPMAS policies and procedures

**Credentialing Process**
All applications will be processed and verified according to KPMAS credentialing policies and procedures. The elements of the initial credentialing process include, but are not limited to, the following:

- Application

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Site Visits
KPMAS Participating Primary Care Physicians, OB/GYN, and high volume Behavioral Health offices will be subject to a site visit. This site visit includes a review of medical record-keeping practices. The Mid-Atlantic States Credentialing and Privileging Committee and Regional Quality Assurance/Quality Improvement Committee use the review results in the selection and ongoing quality monitoring of network sites. Additional site visits may be conducted as needed based on member complaints or to meet an action plan for a previously identified deficiency. Feedback is provided to each practice with the completed site review tools and request for action plan if indicated.

Participating Hospital Privileges
It is the policy of KPMAS to contract with and credential only those practitioners who have privileges at a participating hospital. In the event that there is a change in participating hospitals, Participating Providers with privileges at a terminated hospital will be notified of the change in hospital status, and of the need to obtain privileges at an alternative participating hospital or terminate their participation with Kaiser Permanente.

Board Certification Policy
If not already board certified, all physicians are required to obtain ABMS-recognized board certification in their contracted specialty within five (5) years of completion of training. Physicians must maintain specialty board certification throughout the life of their employment or contract with MAPMG. Providers whose certification lapses during the course of their contract or employment will be given two (2) years following the expiration of their board certification to obtain recertification (MAPMG hourly physicians are not given the two (2) year grace period). Physicians who were practicing in a specialty prior to the establishment of board certification of that specialty are exempt from this policy with respect to that specialty. The following boards are accepted by KPMAS:
- American Board of Medical Specialties (ABMS)
- American Podiatric Medical Association (APMA)
Board Certification Exception Policy
Exceptions to the requirement for board certification of Participating Providers in the specialty for which they deliver care to KPMAS members may be made in individual circumstances in accordance with the principles outlined in the MAPMG Board Certification Policy.

10.6 Re-credentialing Process
After initial credentialing, KPMAS Participating Providers will be re-credentialed every three (3) years except for those with Kaiser Permanente ambulatory surgery and moderate sedation privileges who shall be re-credentialed every two (2) years by following the applicable accreditation agency guidelines, such as those set forth by the NCQA and Kaiser Permanente. The elements of the re-credentialing process include, but are not limited to, the following:

- Application
- Current and unrestricted license in each jurisdiction where the practitioner provides services
- Out-of-state License sanctions
- DEA Certificate in each jurisdiction where the practitioner provides services
- CDS Certificate
- Board Certification and Maintenance of Board Certification
- Current Post-Graduate Education
- Hospital Privileges
- References
- Professional Liability Coverage
- Claims History
- NPDB Query
- HIPDB Query
- Work History
- Medicare and Medicaid Status and Sanctions
- Mid-Level Practitioner Practice Agreement
- Practitioner Quality Profile

Notification
It is incumbent upon Participating Providers to notify PPQA at (301) 816-5853 regarding any updates or changes to their application or credentials within thirty (30) days of the occurrence. These updates and/or changes will be reviewed according to the credentialing procedures outlined by KPMAS and will be included in the Participating Provider Credentials file. These may include, but are not limited to, the following:

- Voluntary or involuntary medical license suspension, revocation, restriction, or report filed
- Voluntary or involuntary hospital privileges reduced, suspended, revoked, or denied
• Any disciplinary action taken by a hospital, HMO, group practice, or any other health provider organization
• Medicare or Medicaid sanctions, or any investigation for a federal healthcare program
• Medical malpractice action

10.7 Provider Profiling
As part of our mission and commitment to our member, KPMAS monitors care and service delivery by measuring several quality indicators to assess effectiveness. KPMAS’ Participating PCPs participate in this effort to ensure quality care. KPMAS has established thresholds for performance measures in key areas that may include customer satisfaction, referral, and quality measures, among others.

Satisfaction measures consist of three components:
1. Overall satisfaction with the office visit,
2. Satisfaction with wait times for telephone answering, scheduling an appointment, and the waiting room,
3. Rate of members transferring out of the primary care office and into another practice (excluding members leaving the plan).

Clinical quality measures are indicators of quality and appropriateness of care. KPMAS approved guidelines, Health Plan report cards, and national statistics may be included in a comparative data analysis.

Member Complaints & Grievances All quality-related complaints and grievances are tracked and trended through KPMAS Quality Management and may become part of Participating Providers profiles.

Referral measures measure the rate of visits for both specialty care and emergency room visits per thousand members. This rate, for example, could be compared to a range of PCP office practices.

Utilization statistics that reflect rates and patterns of care will be presented along with appropriate benchmarks, where possible.

HEDIS/NCQA Quality indicators are used as measures of practitioner and health plan performance in the delivery of care. Selected services are evaluated and reported monthly and annually. Some quality indicators currently being measured are outlined below.
• Childhood immunizations – complete by age two (2) the following: 1 MMR, 4 Dtap/DT, 3 IPV, 3 HiB, 3 HepB, 4 PCV, and 1 Varicella.
• Adolescent immunizations – complete by age 13 the following; 1 MMR (between age 11 and 13) and 1 Td/Tdap (between age 10 and 13). Females – complete by age 13 three doses of HPV vaccine between age 9 and 13).
• Colorectal Cancer screening – age range 50-75 who have had colorectal cancer screening (colonoscopy in the previous ten (10) years, flexible sigmoidoscopy in the previous five (5) years, or FIT in the previous one (1) year).
• Breast Cancer screening – The percentage of female members between ages 52–74 who had at least one mammogram within the previous 27 months
• Cervical Cancer screening – The percentage of female members age 24–64 who had at least one Pap test within the previous 3 years OR female members age 30-64 who
had at least one Pap test and one HPV test (i.e. co-test or separate tests within 4 days of each other) within the previous 5 years.

- **Blood Pressure control** – percentage of members ages 18 and over with hypertension and a last blood pressure below 140/90 mmHg.
- **Blood Pressure control** – percentage of members ages 18 and over with diabetes and a last blood pressure below 140/90 mmHg.
- **Asthma Ratio** – age range 5 to 64 who had an asthma medication ratio ≥ 0.5 in the prior 12 months.
- **Spirometry for people newly diagnosed for COPD** - age range 42 years and older with a new diagnosis or a newly active COPD/Emphysema/Chronic Bronchitis should have a spirometry test either fewer than 2 years before the diagnosis date or 6 months after the diagnosis date.
- **Anti-depressant medication management** – percentage of members on an anti-depressant medication for depression who have remained on the medication for 3 and 6 months.
- **Follow up after hospitalization for mental illness** – percentage of members who were discharged from the hospital with a mental health diagnosis with a follow up appointment within 7 and again within 30 days.
- **Glycemic control for people with diabetes** - age 18 to 75 with diabetes (type 1 and type 2) whose most recent A1c reading within the past 12 months was ≤ 9.0%.
- **Lipid control for people with diabetes** - age 18 to 75 with diabetes (type 1 and type 2) whose most recent LDL reading within the past 12 months was < 100 mg/dL.

### 10.8 Medical Record-Keeping Practices

KPMAS Participating Providers are responsible for maintaining the full medical record of members who elect to receive their health care through their office. The KPMAS Medical Care Program has developed specific criteria for maintaining the medical record. These standards are a part of the periodic site review done within each network office. The standards for medical record-keeping practices and the standard requirements for medical charts are as follows:

#### Standards for Medical Record-Keeping Practices

1. Medical records are maintained in a confidential manner, filed in a locked cabinet and out of public view
2. Each patient has an individual medical record. Individual medical records can be easily retrieved from files, filed alphabetically or numerically
3. Each page is identified with name of patient and birth date, or medical record number
4. All progress notes are dated (including year); provider can be identified; signatures include title
5. There are biographical/personal data
6. Notes are legible
7. There is a date for return visit or a follow-up; plan for each encounter
8. Consultants’ summaries, laboratory and imaging study results reflect primary physician review
9. Allergies and adverse reactions to medications are prominently displayed
10. There is a note from a consultant in the record if a consultation is requested
11. Significant illnesses and medical conditions are indicated on the problem list
12. There is a completed immunization record

#### Standards for Medical Records for Medical Charts:

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1. Clearly identifiable member information on each page:
   - Name
   - Date of birth/age
   - Sex
   - Medical record number
   - Physician name
   - Physician identification number

2. All progress notes will:
   - Be dated (including the year)
   - Clearly identify the provider
   - Include appropriate signatures and titles

3. Patient biographical/personal data are present
4. Notes are legible
5. Working diagnoses are consistent with findings
6. There is clear documentation of the medical treatment received by the patient
7. Plans of action and treatment are consistent with diagnosis(es)
8. There is a date for a return visit of other follow-up plan for each encounter
9. Unresolved problems from previous visit are addressed
10. There is evidence of appropriate use of consultants
11. There is evidence of continuity and coordination of care between primary and specialty physicians
12. Consultant summaries, laboratory, and imaging study results reflect ordering physician review as evidenced by:
   - Initials of the referring PCP following review
   - Recorded date of review
   - Comments recorded in progress note regarding interpretation and findings
   - Indication of treatment notice to patient

13. Allergies and adverse reactions to medications are prominently displayed. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record

14. There is documentation of past medical history as regards diagnoses of permanent or serious significance, and past surgeries or significant procedures. Pediatric patients will have similar documentation and/or prenatal and birth information
15. If a consultation is requested, there is a note from the consultant in the record
16. Significant illnesses and medical conditions are indicated on the problem list
17. There is a notation concerning use/non-use of cigarettes, alcohol, and substance abuse for patients 12 years of age and over
18. The history and physical document examination results with appropriate subjective and objective information for presenting complaints
19. There is evidence that preventive screening and services are offered in accordance with KPMAS’s practice guidelines
20. The care appears to be medically appropriate
21. There is a completed immunization record and problem list

10.9 Participating Provider Responsibility for Patient Confidentiality
As part of their contract with KPMAS, all members are assured that all personal and medical information pertaining to them remains confidential. To this end, it is the shared responsibility of

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all Participating Providers and their staff to maintain patient confidentiality. Participating Providers must follow the level of confidentiality maintenance as stated in Section 7.3. Participating Provider responsibilities to members are detailed in Section 7.4.

10.10 Advance Directives

Advance Directives are written instructions, such as a living will or a durable power of attorney for health care, recognized under appropriate state law. Advance Directives are detailed in Section 7.8.

10.11 Self-Care and Prevention

The Regional Health Education, Health Promotion, and Women’s Health Program (Regional Program) administers a comprehensive health education and prevention plan for informing and encouraging members to use educational services, tools, and resources to practice healthy behaviors and self-manage ongoing conditions. The Regional Program helps ensure that Kaiser Permanente members learn appropriate and effective prevention and self-care through evidence-based medicine and provides members with the information, skills, and confidence to prevent or manage specific health problems through an active partnership with their health care team. Regional Program work and support involves the skill-sets of a diverse team specialized in health education and is guided by clinical subject matter experts who direct the clinical content and accuracy of the educational tools and resources provided to members. Programs are also integrated into the electronic medical record (EMR), providing providers and other team members the ability to directly promote and/or register patients for programs.

Healthy living classes provide self-management skill building in a group setting and are available to all members at no additional cost. Registration for classes is coordinated by health care teams and scheduled through the electronic medical record (EMR) and the centralized Contact Center. Classes range in length between one time meeting and multi-session. All classes are designed to support care recommendations and healthy lifestyle goals set forth by health care teams. Class curricula utilize the concepts of adult learning theory and teach-back instruction in order to engage participants in dialogue. Participants are encouraged to continue their efforts by working with their health care teams and utilize resources distributed and discussed in class. Online classes are also being offered for some topics. The following class topics are currently available:

- Prevention
- Disease Management
- Prenatal and Parenting classes
- Older adult classes

Kaiser Permanente's Web site offers convenient services, instant information and personal advice from health care professionals. Services include Pediatric preventive care and adult preventive care guidelines, the Healthwise Knowledgebase (online health encyclopedia), online health education videos and audio podcasts, prescription and non-prescription drug encyclopedia, the ability to ask an advice nurse or pharmacist a question and receive a response within 24 hours, links to health-related resources, and more.

The web site also offers customized online programs for health risk appraisal (total health assessment), weight management/physical activity, nutrition, stress management, caring for chronic conditions, and tobacco cessation, which assess health risk, readiness to change lifestyle behaviors, and self-efficacy.

Members also have access to online procedural preparation and chronic condition management.
videos that allow them to view what to expect of a medical procedure or how to manage certain aspects of their care. These programs are available through every primary and specialty care physicians’ home page accessible through My Doctor Online at kp.org/doctor.

Members have access to wellness coaches via telephone appointment, with health education professionals skilled in motivational counseling techniques, to discuss lifestyle behaviors that impact the risk and management of chronic conditions. Coaching session topics include healthy eating, physical activity, stress management, tobacco cessation, and weight management. Sessions address members’ ambivalence to change, and based on preferences, the member is referred to other program resources (i.e. classes, online tools). Coaching sessions, which are available in English and Spanish, are set in 20-minute time frames, with no limit to the number of sessions scheduled.

The Prenatal Education program provides tools and resources to women or couples who are considering pregnancy all the way through delivery to ensure they receive timely care and screenings. Members can attend four classes on prenatal education at a medical center near them to help prepare for caring for a newborn. Breastfeeding assistance is provided under the program through IBCLCs (see below). The Prenatal Education program consults with health care team staff to ensure that all materials and tools being developed are consistent with the needs of the members.

The Regional Program promotes and markets available tools, resources and classes for members through:
- member mailings of class schedules and online tools;
- specific class flyer mailings to target audiences;
- using the Kaiser Permanente website,
- digital signage in some medical centers,
- promotion of programs and classes through other classes, and
- a health education line that members can call to learn more about class offers or leave messages if there are any questions.

10.12 Managing Chronic Diseases Program (Disease Management)
KPMAS care management programs help participating practitioners monitor and manage patients with chronic conditions. Members with diabetes, asthma, coronary artery disease, chronic kidney disease, hypertension, and/or depression are enrolled into care management programs through a registry.

These programs are designed to engage patients to help care for themselves, better understand their condition(s), update them on new information about their disease, and help manage their disease with assistance from their health care team and the population care management department. This information and education is designed to reinforce the patient’s treatment plan.

Members in these programs receive mailings when they are initially identified as having one of these conditions and mailings and/or phone calls periodically thereafter, including care gap reminders. The mailings and additional multi-media resources introduce the programs and provide education on topics such as the latest information on managing their condition, physical activity, tobacco cessation, medication adherence, planning for visits and knowing what to expect, and coping with multiple diseases. Participating practitioners may receive member-level information to help manage their panel, and quality process and outcome information to help improve practices. In addition, you can receive tools, including posters and pocket cards.
Patients do not have to enroll in the programs; they are automatically identified into a registry. If there are patients who have not been identified for program inclusion, or who have been identified as having a condition but do not actually have the condition, they can be "activated" or "inactivated" from the program by sending an e-mail to CarePOINT-MAS@kp.org with their contact information to receive a call back to garner the patient's PHI. Or, call the Population Care Management message line anytime at (703) 536-1465 in the Washington Metro area or (410) 933-7739 in the Baltimore area. Members can choose not to participate or can self-enroll by calling our message line anytime at (703) 536-1465 in the Washington Metro area or (410) 933-7739 in the Baltimore area. For TTY access, dial 711.

To obtain information and tools to care for your patients with chronic diseases, register at https://mapmgonline.com or contact Betina Pereira, Population Care Management at (301) 816-7122, or the Provider Relations Department at 1 (877) 806-7470.

### 10.13 Provider Demographic Changes-New Locations and Relocations of Practice

When initiating a provider demographic request for a new location or relocation, all requests must come from the provider on company letterhead. This request can be submitted via fax at 855-414-2623 or thru the Provider Relations email address: provider.relations@kp.org. The demographic requests will be reviewed by a member of our Provider Contracting team. The review process will be completed within thirty (30) business days from date of receipt and a decision will be communicated via letter, unless credentialing is required for the demographic request. Please refer to section 10.5 Credentialing and Re-credentialing Process. Services should not be rendered to our members at your new location or relocation until your requested change has been approved by Kaiser Permanente. Please refer to the following page for a sample of the Provider Demographic Request Form.
Requestor:
Requestor’s Correspondence Address:
Requestor’s Phone #:
Email:
Tax ID#:
Effective date of change(s):

Reason for the request:

Address change (Specify if practice location or billing address is changing)
- Specify if adding or deleting address
- Include old and new demographic information when sending request
   (Street Address, City, State, Zip, Phone, Fax and NPI)
- Billing/Payment Address
- Management Correspondence Address (include Phone & Fax Number)
- Include a signed and dated copy of the new W-9

Adding a provider to an existing group or Deleting a provider from an existing group
- Specify if adding or deleting provider
- Include a signed and dated copy of the new W-9
- Include the below listed information if adding or deleting a provider:
  - First Name, Middle initial, and Last Name
  - Gender
  - Title or Degree
  - NPI #
  - CAQH #
  - UPIN or SSN
  - Medicare #
  - Medicaid Participation State(s)
  - Medicaid #
  - Primary Specialty (include secondary specialty if applicable)
  - Practice location (include Phone & Fax Number)
  - Billing/Payment Address
  - Management Correspondence Address (include Phone & Fax Number)
  - Foreign Languages
  - Effective date

Changing the Tax Identification Number and/or the name of an existing group
- Include old and new Tax ID Number and/or group name
- Include effective date of the new Tax ID Number and/or group name
- Include a signed and dated copy of the new W-9
- Billing/Payment Address
- Management Correspondence Address (include Phone & Fax Number)

**Email your letter to the Provider Relations Department at Provider.Relations@kp.org or fax to 855-414-2623.