



The Provider Demographic Maintenance Form (PDMF) is to be used by participating physicians, behavioral health providers, practitioners, facilities, and ancillary providers to request updates to their provider records with The Holman Group.

Maintaining accurate provider information is critical to ensuring members have timely access to care and receive current provider directory information. Accurate provider data also supports compliance with applicable federal and state regulatory requirements, including provider directory accuracy, network adequacy, and timely access standards.

Changes to provider records affiliated with a group practice, facility, or organization should be submitted by the practice administrator, credentialing representative, office manager, or another authorized individual. Changes related to individually contracted providers may be submitted directly by the contracted provider.

Providers are required to notify The Holman Group of demographic, practice, and provider directory changes as soon as possible and no later than five (5) business days following the effective date of the change.

Examples of changes that should be reported include, but are not limited to:

- Provider or practice name changes
- Practice, mailing, payment, or remittance address changes
- Tax Identification Number (TIN) changes
- National Provider Identifier (NPI) updates
- Telephone, fax, email, or website changes
- Office hours or days of operation
- Provider joining or leaving a practice or group
- Opening or closing a practice location
- Acceptance of new patients
- Telehealth availability
- Languages spoken by providers or office staff
- Specialty services offered
- Areas of expertise and populations served
- Hospital affiliations or privileges
- Accessibility accommodations available at the practice

Instructions for Completing and Submitting the Form

A. Complete Applicable Sections

This form contains multiple sections designed to accommodate various types of provider updates. Complete only those sections that apply to the requested change(s). Incomplete forms may delay processing.

B. Supporting Documentation

Certain changes require supporting documentation. Examples include:

- Tax Identification Number (TIN) changes — Current IRS Form W-9 required
- Practice or legal entity name changes — Current IRS Form W-9 required
- License changes — Copy of current license or certification, if applicable
- EFT/ACH changes — ACH Enrollment Form, voided check, or bank verification letter, if applicable

C. Submit the Completed Form and Supporting Documentation

Completed forms and supporting documentation may be submitted to:

| Mail | Email | Fax |
|---|--|--------------|
| P.O. Box 8011, Canoga Park, CA 91309 | PR@holmangroup.com | 818-346-3753 |

Providers should retain a copy of all submitted documentation for their records.

If you have questions regarding this form or the provider update process, please contact Provider Relations at 800-321-2843.



| General Information | |
|---------------------------------|---|
| Effective Date: | |
| Provider Name: | |
| Professional Title: | |
| Individual TIN: | |
| Individual NPI: | |
| License Number: | |
| Provider Type: | |
| Provider Specialty: | |
| Practice Information | |
| Practice Name: | |
| Practice TIN: | |
| Organization NPI: | |
| License Number: | |
| Contact Person: | |
| Email: | |
| Phone: | |
| Languages Spoke: | |
| Practice Type: | |
| Provider Directory Information | |
| Telehealth Available: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Telehealth Modalities: | <input type="checkbox"/> Video <input type="checkbox"/> Telephone <input type="checkbox"/> Hybrid |
| Populations Served: | |
| Age Groups Served: | Children: <input type="checkbox"/> 0-5 years <input type="checkbox"/> 6-12 years Adolescent <input type="checkbox"/> 13-17 years Adult: <input type="checkbox"/> 18-64 years Geriatric: <input type="checkbox"/> 65+ years |
| Evening Appointments Available: | |
| Weekend Appointment Available: | |
| Appointment Availability | <input type="checkbox"/> Urgent <input type="checkbox"/> Non-Urgent <input type="checkbox"/> Follow-up Appointment Availability |
| Accessibility: | <input type="checkbox"/> ADA Accessible Office <input type="checkbox"/> Wheelchair Accessible <input type="checkbox"/> TTY/TDD Available <input type="checkbox"/> Interpreter Services Available |



Behavioral Health Areas of Expertise and Levels of Care

- Substance Use Disorders
- Co-Occurring Disorders
- Children/Adolescents
- Adults
- Older Adults
- Trauma/PTSD

- LGBTQ+ Populations
- Eating Disorders
- Autism Spectrum Disorders
- Military/Veterans
- Couples/Family Therapy
- MAT Services

Demographic Changes Requested

- Practice Address Change
- Phone/Fax Change
- Add New Location
- Close Location
- Provider Leaving Group
- Payment/Remittance Address Change
- Office Hours Change

- New Patient Status Change
- NPI Update
- Email Update
- Language Update
- Specialty/ Provider Type Update
- TIN Change (W-9 Required)
- Practice Name Change (W-9 Required)

Details of Change

Previous Information:

Updated Information:

Attestation

I certify that the information submitted is true and accurate and that I am authorized to request these changes on behalf of the provider/practice.

| | | | |
|-------------------|--|--------------|--|
| Signature: | | Date: | |
|-------------------|--|--------------|--|