



**HP ENTERPRISE SERVICES - TPL CHANGE REQUEST FORM**

\*Provider Name: \_\_\_\_\_ \*Provider NPI #: \_\_\_\_\_

\*Individual Making Request: \_\_\_\_\_ \*Contact #: \_\_\_\_\_

\*Recipient Name: \_\_\_\_\_ \*Medicaid UID #: \_\_\_\_\_

\*FULLY EXPLAIN THE CHANGES REQUESTED: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If coverage does not exit attach a denial EOB or complete website print out.

**New Policy Information:**

\*Insurance Company Name: \_\_\_\_\_ \*Phone Number: \_\_\_\_\_

\*Street Address: \_\_\_\_\_ \*City: \_\_\_\_\_

\*Zip Code: \_\_\_\_\_

\*Policy Holder Name: \_\_\_\_\_ \*Policy Number: \_\_\_\_\_

\*Employer: \_\_\_\_\_ \*Group Number: \_\_\_\_\_

\*Effective (Start) Date: \_\_\_\_\_ \*End Date: \_\_\_\_\_

\*Coverage Type: Dental \_\_\_ Major Medical \_\_\_ Outpatient/Inpatient \_\_\_ Pharmacy \_\_\_  
MCR Supplement \_\_\_ Vision \_\_\_

\*\*\*\*\*Please attach print out from OI website\*\*\*\*\*

<b><u>FOR INTERNAL USE ONLY:</u></b>

\*Indicates mandatory fields. Please submit requests to: TPL via fax at 1-802-857-2992 or submit via mail to: HP Enterprise Services, ATTN: TPL, PO Box 888, Williston, VT 05495.