PRINT CLEAR

For DWC only: MPN Identification Number	Date Notice Received:

Notice of Medical Provider Network Plan Modification §9767.8

1. Legal Name of MPN Applicant_____

2. Name of MPN and MPN Identification Number_____

3. MPN Applicant Address

_____

_____

4. Tax Identification Number____--_____

5. Signature of authorized individual: "I, the undersigned officer or employee of the MPN Applicant, have read and signed this application and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this modification is true and correct."

_____

Name of Authorized Individual | Title | Organization

_____

Phone | Email

_____

Signature of Authorized Individual | Date Signed

6. Authorized Liaison to DWC:

_____

Name | Title | Organization

_____

Phone | Email

_____

Address | Fax number

7. Please give a short summary of the proposed modifications in the space provided below and place a check mark against the box that reflects the proposed modification.

_____

_____

_____

☐ Change of MPN name or MPN Applicant name: Provide new name and plan sections affected by the change within fifteen (15) business days of the change.

☐ Change in MPN Applicant eligibility status. Provide date of change in eligibility and reason for change. Must file within fifteen (15) business days of change in status.

☐ Change of Division Liaison or Authorized Individual: Provide the name and contact information within fifteen (15) business days of change.

☐ Change in MPN Service Area: Provide documentation in compliance with section 9767.5.

☐ Change in continuity of care policy: Provide a copy of the revised written continuity of care policy.

☐ Change in transfer of care policy: Provide a copy of the revised written transfer of care policy.

☐ Change in Economic Profiling policy used by MPN Applicant or any entity contracted with MPN: Provide a copy of the revised policy or procedure.

☐ Change in how the MPN complies with the access standards: Explain what change has been made and describe how the MPN still complies with the access standards.

☐ Change in employee notification materials, including a change in MPN contact or Medical Access Assistants contact information, or a change in provider listing access or MPN website information: Provide a copy of the revised notification materials.

☐ Change in use of one of the following Deemed Entities: Health Care Organization (HCO), Health Care Service Plan, Group Disability Insurer, or Taft-Hartley Health and Welfare Trust Fund.

Please state change: From_____ To_____

☐ Revision of any plan section(s) required by sections 9767.3(d)(8) or 9767.3(e) resulting from a change of any MPN administrator(s) listed in the MPN Plan. Please include complete sections revised.

☐ Replacement of entire plan application. Please state why and include entire revised plan.

☐ Update of MPN plan to the current regulations pursuant to section 9767.15. Please include entire updated plan.

Submit two copies of the completed, signed Notice of MPN Plan Modification and any necessary documentation in compact discs or flash drives in word-searchable PDF format to the Division of Workers' Compensation. Mailing address: DWC, MPN Application, P.O. Box 71010, Oakland, CA 94612.

[DWC Mandatory Form -- Section 9767.8 -- 8/14]