

# Provider Information Update/Change

Fill out the practitioner section of this form if you have a practitioner update. Fill out the facility section if you have a facility update. **We request a 60-day notice to be able to communicate these changes to our members.** If more room is needed, please attach an additional sheet listing your changes.

Clinic/Facility name: \_\_\_\_\_ Tax ID number: \_\_\_\_\_ Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Signature: \_\_\_\_\_ (phone number of person filling out this form)

Practitioner

### Add/Remove Provider

*If additional room is needed for provider changes, please list them on a separate sheet and include it with this completed form.*

Provider name:		Title:	NPI:	
DOB:		SSN:		
License number:		State:	Exp. Date:	
Practicing specialty:		Languages:		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Clinic/Hospital Name:		Phone:	
Address:		City/State:	Zip:	
Tax ID:	Group NPI:		Primary site? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		Directory suppress? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Practicing As: <input type="checkbox"/> Hospital Based Only		<input type="checkbox"/> Hospitalist	<input type="checkbox"/> Locum Tenens	<input type="checkbox"/> Urgent Care <input type="checkbox"/> Resident
<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE	Reason employment ended:		Effective date:	

### Provider Demographic Change: provide legal document

Provider NPI:			
Provider's previous name:		Provider's new name:	
Old license number:	State:	New license number:	State:

Facility

### Clinic/Facility Name Change

Previous Clinic Name:		New Clinic Name:	
Effective Date:	Facility NPI number:	Billing NPI number:	
Clinic/Facility is ADA Compliant <input type="checkbox"/>			

### Tax Identification Number Change: submit a completed W-9 form

Previous Tax ID number:		New Tax ID number:	<input type="checkbox"/> Profit <input type="checkbox"/> Non-profit
Effective Date:	List entities included:		

### Telephone number change

Previous phone number:		New phone number:	Effective date:
<input type="checkbox"/> Clinic phone <input type="checkbox"/> Billing office <input type="checkbox"/> Central business office <input type="checkbox"/> Other			

### Physical/Mailing/Billing address change

<input type="checkbox"/> Office/Facility address (physical location) <input type="checkbox"/> Mailing location <input type="checkbox"/> Billing address		Effective date:
Previous physical:		New physical:
Previous mailing:		New mailing:
Previous billing:		New billing: