PROVIDER CHANGE FORM:

Last Name:	Degree:
First Name:	TAX ID:
MI	Medicaid#
Solo Contract: ◻ Yes ◻ No	Taxonomy#
Group Contract ◻ Yes ◻ No	NPI#

Type of Change (please check appropriate box):

◻ IF Change of physical addresses, telephone, and/or fax number **(COMPLETE SECTION A)**
◻ IF Change /add secondary address, telephone, and or fax number **(COMPLETE SECTION B)**
◻ IF Change of billing address, telephone, and or fax number **(COMPLETE SECTION C)**
◻ IF Change of mailing address, telephone, and or fax number **(COMPLETE SECTION D)**
◻ IF Change of provider status (e.g. moved out of area, panel closing, capacity changes, etc.
(COMPLETE SECTION E)

SECTION A

PLEASE NOTE: THE PHYISCAL LOCATION CAN NOT BE P.O. Box #

Previous Practice Location:	**New Practice Location:**
Address:	Address:
Phone #:	Phone #:
Fax:	Fax:
Email Address:	Email Address:

What are your office hours for this location?

MONDAY	
TUESDAY	
WEDNESDAY	
THURSDAY	
FRIDAY	
SATURDAY	
SUNDAY	

Identify the percentage of your practice dedicated to treating the following patient populations;
(Total must equal 100%)

Young Child (0-5 yrs.) ____ % Child (6-11 yrs.)_______% Adolescent (12-17 yrs.) _______%

Adult (18-64 yrs.) ______% Geriatric (65+) _______%

SECTION B

Adding a second location: Does Tax ID information changes? □ yes □ no

IF YES, PLEASE CONTACT YOUR PR REPRESENTATIVE

Second Location Address:	
Phone #:	Fax#:
Email Address:	Contact Name:

What are your office hours for this location?

MONDAY	
TUESDAY	
WEDNESDAY	
THURSDAY	
FRIDAY	
SATURDAY	
SUNDAY	

Identify the percentage of your practice dedicated to treating the following patient populations;
(Total must equal 100%)

Young Child (0-5 yrs.) ____ % Child (6-11 yrs.)_______% Adolescent (12-17 yrs.) _______%

Adult (18-64 yrs.) ______% Geriatric (65+) _______%

SECTION C

Changing Billing Address and or Billing Information: <u>THIS WILL REQUIRE A NEW W9</u>

New Billing Address:	
Phone #:	Fax #:
TAX ID#	
Exact name reported to the IRS for this Tax ID:	
Email Address:	Contact Name:

SECTION D

Changing Mailing Address:

New Mailing Address:	
Phone #:	Fax #:
Email Address:	Contact Name:

SECTION E

Change of Provider Status:

Type of Change:

____

Explanation:

____

____

____

Name of Individual submitting form: ______________________________________

Date:____

Special Notes/Comments:

____

____

____