Provider Information Update Form

Please review the items below carefully. Each section has a remove/current option. Please ensure you provide all necessary documentation in order for IMHS to accurately update our system. Please return completed form to the following:

IMHS
Attn: Provider Relations
504 Lavaca Street, Suite 850
Austin, TX 78701

Practitioner Name: ______________________________ **License Type:** ______________

Medicaid Number: ______________________________ **NPI:** ______________

1) The TIN listed below is a: ☐ TIN Currently in Use ☐ New TIN (Please attach a W-9)

Tax ID # ☐☐☐☐☐☐☐☐☐ TIN Owner Name: ______________________________

Note: If you have more than one service address for the above listed TIN, please copy this form and list each corresponding service address in Section 2 of the form so that CBH can load each referral location.

*All addresses listed below must correspond to the TIN listed in Section 1 above. If you have more than one TIN, please copy this form and complete a separate form for each TIN. **A W-9 is required for all financial address changes.**

2) Delete this SERVICE address: (Referrals)	**Add/Keep this SERVICE address:**
Street/ Suite #	Street/ Suite #
City State Zip	City State Zip
(_____) Phone	(_____) Phone
Effective Date: _/_____/_____	**Effective Date: _/_____/_____**

3) Delete this MAILING address: (Auth Letters)	**Add/Keep this SERVICE address:**
Street/ Suite #	Street/ Suite #
City State Zip	City State Zip
(_____) Phone	(_____) Phone
Effective Date: _/_____/_____	**Effective Date: _/_____/_____**

4. Delete this FINANCIAL address: (Checks)	**Add/Keep this FINANCIAL address:**
Street/ Suite #	Street/ Suite #
City State Zip	City State Zip
(_____) Phone	(_____) Phone
Effective Date: _/_____/_____	**Effective Date: _/_____/_____**

Remember to submit a W-9 for a financial address change.

Provider Signature (Required): ______________________________ **Date:** ______________