

Provider Change Form



Today's Date:		Effective Date of Change:	
Type of Agreement (please check one):			
<input type="checkbox"/> Solo/Individual Provider – Name: _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Last First MI </div>			
<input type="checkbox"/> Group Provider – Group Name: _____			
<input type="checkbox"/> Facility Provider – Facility Name: _____			
Clinic Name (if applicable):			
TAX ID:		Medicaid#:	
NPI#:		Taxonomy#:	
Licensure:		Facility Accreditation:	
State of Licensure:		Group/Facility Contact Person:	
Phone Number:		Email Address:	

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, capacity changes, etc.) **(COMPLETE SECTION E)**

Section A: CHANGE IN PHYSICAL ADDRESS, PHONE OR FAX

NOTE: Physical location will be included in provider directory; must be a street address (not a PO Box)

Previous Practice Location:	New Practice Location:
Facility/Clinic Name:	Facility/Clinic Name:
Address:	Address:
County:	County:
Phone #:	Phone #:
Fax:	Fax:
Contact Person:	Contact Person:
Email Address:	Email Address:
Medicaid #	Medicaid #

Office Hours at this location?

MONDAY		THURSDAY		SATURDAY	
TUESDAY		FRIDAY		SUNDAY	
WEDNESDAY					

Identify the % of your practice dedicated to treating the following 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: CHANGE IN SECOND LOCATION ADDRESS, PHONE OR FAX (If yes, contact your
Does the tax ID information change for this location? YES NO *Provider Relations Specialist*)

Facility/Clinic Name:	
Second Location Address:	
County:	
Medicaid#	
Phone #:	Fax#:
Email Address:	Contact Name:

Office Hours at this location?

MONDAY		THURSDAY		SATURDAY	
TUESDAY		FRIDAY		SUNDAY	
WEDNESDAY					

Identify the % of your practice dedicated to treating the following 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: CHANGE IN BILLING ADDRESS OR BILLING INFORMATION

(Changes in billing address or information require a new W9)

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

Section D: CHANGE IN MAILING ADDRESS

Facility/Clinic Name:	
New Mailing Address:	
Phone #:	Fax #:
Email Address:	Contact Name:

Section E: CHANGE OF PROVIDER STATUS *Type of change (moving out of state/retiring, discontinuing service, closing an office/location, termination):*

Explanation for the change:

Mail or fax the completed form to: Cenpatico, Provider Relations Department
 504 Lavaca, Suite 850, Austin, Texas 78701 Fax#: 866-739-3424

 Signature

 Date