

# Provider Change Form



<b>Today's Date:</b> _____		<b>Effective Date of Change:</b> _____	
<b>Type of Agreement (please check one):</b>			
<input type="checkbox"/> Solo/Individual Provider – Name: _____ <div style="display: flex; justify-content: space-around; width: 100%;"> <span><b>Last</b></span> <span><b>First</b></span> <span><b>MI</b></span> </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)*

<b>Previous Practice Location:</b>	<b>New Practice Location:</b>
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?

<b>MONDAY</b>		<b>THURSDAY</b>	
<b>TUESDAY</b>		<b>FRIDAY</b>	
<b>WEDNESDAY</b>			
			<b>SATURDAY</b>
			<b>SUNDAY</b>

**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?**

<b>MONDAY</b>		<b>THURSDAY</b>		<b>SATURDAY</b>	
<b>TUESDAY</b>		<b>FRIDAY</b>		<b>SUNDAY</b>	
<b>WEDNESDAY</b>					

**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