

Steps for Submission:	<ol style="list-style-type: none"> 1. Complete the Provider Demographic Update form with all current information. 2. Email the form by clicking the Submit by Email button, or if faxing, use the Print Form button (located at the bottom of form) to print. Fax form to: 1-888-244-4025. 3. If you need to include a W-9, or additional location information, attach extra information to your email along with this form. If you are faxing, fax your W-9 and any additional information along with this form.
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Current Information (Required)	Group/Provider Name	
	National Provider Identifier	Tax Identification Number
	Does update apply to all providers under the TIN? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, list applicable provider IDs

Tax Identification Number Change (If applicable) Note: You will need to include a W-9.	Tax Identification Number	Effective Date
	Terminate TIN	Termination Date
	Reason for Termination	

Name Change (If applicable)	New Provider Name
	New Group Name (Attach new W-9)

Address Changes

Primary Address (If applicable)	<input type="checkbox"/> New Address	<input type="checkbox"/> Updated: Suite/Fax/Telephone/Email	Effective Date
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Street		Suite Number
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City	State	ZIP Code
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Email Address

Telephone	General Fax	Referral Fax
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Billing Address (Include W-9)	<input type="checkbox"/> New Address	<input type="checkbox"/> Updated: Suite/Fax/Telephone/Email	Effective Date
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Street		Suite Number
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City	State	ZIP Code	Telephone	Fax
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Additional Location (Attach page to email with additional information for more than one additional location)	<input type="checkbox"/> New Address	<input type="checkbox"/> Updated: Suite/Fax/Telephone/Email	Effective Date
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Street		Suite Number
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City	State	ZIP Code	Telephone	Fax
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Practitioner Termination Request

Practitioner Name		Individual Practitioner NPI	
Effective Date of Termination	Reason for Termination		
Reassign Members (Primare care managers only) <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, practitioner to reassign to:		
Forwarding Information			
Delete Location (If applicable)		Effective Date	
Street			Suite Number
City		State	ZIP Code
Email Address			
Telephone	General Fax	Referral Fax	
Sender's Email Address			

Printed Signature (Fax Only) _____

Current Date

Electronic Signature (Email Only)

Print Form

Submit by Email