



# Provider Change of Information Form

Fill out only those sections of the form for information that is changing.  
Questions? Call Professional Relations at 1-800-933-3920

Provider Name \_\_\_\_\_ Provider # \_\_\_\_\_  
Specialty \_\_\_\_\_ Effective Date of Change \_\_\_\_/\_\_\_\_/\_\_\_\_

### CHANGE OF SERVICE ADDRESS

Change of Primary Practice Address     Additional Practice Address     Delete Practice Address

Group Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code (plus 4 ) \_\_\_\_\_

Tel # (\_\_\_\_) \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_ After Hours Tel # (\_\_\_\_) \_\_\_\_\_

### CHANGE OF REMITTANCE ADDRESS

(Only one Remit-To address per tax ID per provider is permitted)

Group Practice or Billing Company Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code (plus 4 ) \_\_\_\_\_

**CHANGE TO OFFICE HOURS:** Indicate new office hours: M\_\_\_\_ T\_\_\_\_ W\_\_\_\_ Th\_\_\_\_ F\_\_\_\_ Sa\_\_\_\_ Su\_\_\_\_

Indicate number of hours worked each day M\_\_\_\_ T\_\_\_\_ W\_\_\_\_ Th\_\_\_\_ F\_\_\_\_ Sa\_\_\_\_ Su\_\_\_\_

**CHANGE IN NUMBER OF NPs OR PAs:** Indicate number of each: NPs\_\_\_\_ PAs\_\_\_\_

New NPs/PAs must be registered. Please refer to the registration form on our Web site: [www.mvphealthcare.com](http://www.mvphealthcare.com)

**YOU ARE ACCEPTING THE FOLLOWING NEW PATIENTS:**     Commercial, Gold, ASO     Option

**YOU ARE NOT ACCEPTING THE FOLLOWING NEW PATIENTS:**     Commercial, Gold, ASO     Option

**NEW TAX ID # :** \_\_\_\_\_ **(you must attach W-9)**

New Business     Change of Tax ID#     Joining another existing tax ID/practice

**NEW TAX ID NAME** \_\_\_\_\_ **(you must attach W-9)**

Name assigned to new ID#     New name for existing ID#     Tax ID Name of an existing practice provider is joining

### CHANGE OF BACKUP PROVIDERS

Add Backups (list below)     Remove Backups (list below)    *If more room needed, attach list to this form.*

### PROVIDER TERMINATING FROM PANEL

**Please attach a copy of the letter you or your practice mailed to your patients.**

Reason for Termination:     Relocated out-of-area     Resigned     Retired     Deceased

If you are a PCP, do you wish MVP Health Care to select a PCP(s) to whom to assign your patients?     Yes     No

If no, please list the name (names) of provider(s) who will take patients \_\_\_\_\_

### OTHER CHANGES

Name Change: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

License Change Due to Immigration Status: Former License # \_\_\_\_\_ New License # \_\_\_\_\_

**AUTHORIZED SIGNATURE** \_\_\_\_\_ **Date** \_\_\_\_\_

Provider must sign if provider is terminating from panel.

**Please fax to (585) 327-2289 or (585) 258-8660: Provider Data**