

## PROVIDER CHANGE FORM

Provider Name:	Individual Provider NPI:		
Specialty:	Taxonomy:		
Ethnicity	Additional Language(s) Spoken		
Current Group/Practice Name:			
Provider Primary Practice Location_			
Telehealth availability Yes/ No	Handicapped Accessible: Yes/No		
☐ Change Group/Practice Name to: Group NPI:			
Change Provider(s) Name to: [Please provide supporting documents]	mentation; i.e., current license and/or other proof of name change]		
Change Practice Location Address From (current): To (provide new information): _	s/Phone/Fax:		
Telehealth availability Yes/ N	No Handicapped Accessible: Yes/No		
Delete this Practice Address/Phone	e/Fax:		
	Fax to this Provider:		
☐Board Certification completion: _			
Specialty Change/Correction:	Taxonomy Code:		
Other [detail]:			
PCP's only - Panel Status:	Open Closed Existing Patients Only		
TERMINATION:			
	etice:		
	ractice:		
	ing patient panel: Forwarding phone:		
BILLING INFORMATION:  Any changes related to billing informate	ion (Name, Address, Tax ID, Group NPI) must be accompanied by a completed W9 form		
	x:		
-	nx to this Provider		
Change Tax ID Number: From (cu	urrent): To (provide new Tax ID#):		
Group NPI Number			

Add Tax ID Number:(please note; new or additional Ta	ax ID numbers may require cont	racting updates)
Effective Date of Change(s):		
Print name of person completing this form	Signature of person completing this form	
Title of person completing this form	Phone	Date
Please send completed form to Credentials and Pro Email: credentialing@svcmcny.org  Mail: USFHP – Credentials & Provider Mainte 530 7 <sup>th</sup> Avenue, 10 <sup>th</sup> Floor, New York, N	nance	email, fax, or mail. ax: 646-400-0608

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