



Provider Demographic Change Request Form

INSTRUCTIONS: (Please type or print legible to avoid processing delays)

- ✓ Complete entire form, regardless of the type of changes you are requesting.
- ✓ Be sure to include a W-9. Changes will not be made unless a W-9 is received.
- ✓ Sign and date were indicated.
- ✓ Fax or Email completed form and W-9 to Network Management Services:
 Fax: **1-888-659-0619** Email: **pcpnms-inhouse@uhcsouthflorida.com**

Current Provider Information

Provider Name: _____ Tax ID: _____
 Specialty: _____ Group NPI: _____ NPI: _____

Provider Change Information (This change affects)

Group Practice Individual Provider Institution / Facility Date change will effect: _____

Type of Change (Please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Address Change - Practice / Facility Location | <input type="checkbox"/> (FAX) Number Change - Practice | <input type="checkbox"/> NPI# Add / Change (Specify Group or Individual) |
| <input type="checkbox"/> Address Change - Billing Address | <input type="checkbox"/> Add (FAX) Number | <input type="checkbox"/> TIN or SSN Number Add / Change |
| <input type="checkbox"/> Address Change - Mailing Location | <input type="checkbox"/> (FAX) Number Change - Billing | <input type="checkbox"/> Add a Provider to Practice |
| <input type="checkbox"/> Telephone Number Change - Practice Location | <input type="checkbox"/> (FAX) Number Change - Mailing | <input type="checkbox"/> Medicaid - Medicare Provider Number Add / Change |
| <input type="checkbox"/> Telephone Number Change - Billing Location | <input type="checkbox"/> E-Mail Address Add / Change | <input type="checkbox"/> Taxonomy Codes (Group or Individual) Add / Change |
| <input type="checkbox"/> Telephone Number Change - Mailing Location | <input type="checkbox"/> Location Add / Remove | <input type="checkbox"/> Other Add/Change |

NEW Demographic Information

(Form W-9 must be submitted with all Tax ID updates)

NEW Service Information (If more than one location attach additional sheet) Primary service location? Yes No

Individual Name: _____ Group Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Telephone: _____ Fax: _____
 Tax ID: _____ Group NPI: _____ NPI: _____

OLD Demographic Information

CORRECT CHANGE

(Form W-9 must be submitted with all Tax ID updates)

OLD Service Information (If more than one location attach additional sheet) Primary service location? Yes No

Individual Name: _____ Group Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Telephone: _____ Fax: _____
 Tax ID: _____ Group NPI: _____ NPI: _____

Print Name and Title of Authorized Signature: _____

Telephone: _____ **Email Address:** _____

Authorized Signature: _____ **Date:** _____