



Please fax completed form to: **Health Partners (614)546-4261**

Effective date of change(s): _____

Please list all Physicians who are affected by the changes on this form (attach additional sheet, if necessary)

Physician name(s): _____

Group Practice Name: _____

Tax ID #: _____ NPI: _____ Group NPI: _____

PLEASE CHECK APPROPRIATE BOX(ES)

Physician Changes

New Group/Practice name: _____

New Tax ID #: _____ Add 2nd Tax ID #: _____

Please attach updated W9 for above changes

Delete Tax ID #: _____

Physician(s) joined practice, effective: _____ Physician(s) left practice, effective: _____

Reason for leaving: _____

Location and/or Billing Address Changes

New Primary address: _____

Phone: _____ Fax: _____ Group NPI: _____

New Billing address: _____

New Secondary address: _____

Phone: _____ Fax: _____ Group NPI: _____

New Secondary Billing address: _____

Delete Address(es): _____

Delete Billing address: _____

Correspondence address **ONLY** (if different from primary or billing address): _____

Phone/Fax/Email Change(s)

New/add/delete office phone number(s): _____

New/add/delete office fax number(s): _____

New/add/delete email address(s): _____

Contact: _____ **Phone #:** _____ **Date:** _____