

HEALTHSPAN PROVIDER INFORMATION UPDATE FORM

Section A. GENERAL INFORMATION

Group/Practice Name Solo Practice Group Practice

Practice Tax ID Number Provider Individual NPI Number:
Provider CAQH Number:

Provider First Name MI Last Name Title

Section B. REASON FOR SUBMITTING FORM

- | | | |
|---|--|--|
| <input type="checkbox"/> Practice Name Change Only
<input type="checkbox"/> Practice Name & TIN Change
<input type="checkbox"/> Term Current Practice & TIN
<input type="checkbox"/> Add New Practice & TIN
<input type="checkbox"/> Keep Current Practice & TIN
<input type="checkbox"/> Add Additional Practice & TIN
<input type="checkbox"/> Primary Address Change
<input type="checkbox"/> Secondary Address Change
<input type="checkbox"/> Add Secondary Address
<input type="checkbox"/> Term Secondary Address
<input type="checkbox"/> Practice Phone Change | <input type="checkbox"/> Practice Fax Change
<input type="checkbox"/> Billing/ Remit Address Change
<input type="checkbox"/> Term Current Billing /Remit Address
<input type="checkbox"/> Add New Billing/ Remit Address
<input type="checkbox"/> Billing Phone Change
<input type="checkbox"/> Billing Fax Change
<input type="checkbox"/> Remove Provider from Group | <input type="checkbox"/> Remove Provider from Group – Relocated
To _____.

<input type="checkbox"/> Remove Provider from Group – Retired Effective
_____.

<input type="checkbox"/> Other, please describe

_____ |
|---|--|--|

Date Required Effective Date of Add, Change or Deletion ____/____/____

Please give brief description of change:

Section C. Practice Address Required * Note. If changing address put current address here. Complete billing/ remit address if different from practice address. OLD ADDRESS

Previous Practice Name			Previous Practice Tax ID		
Previous Primary Practice Address			Previous Billing Address		
City	State	Zip	City	State	Zip
County			County		
Phone Number	Fax		Phone Number	Fax	
() _____ - _____	() _____ - _____		() _____ - _____	() _____ - _____	

Section D. Practice Address * *Note. If changing address put new address here.
Complete billing/ remit address if different from practice address.*

NEW ADDRESS

New Practice Name			New Practice Tax ID		
New Primary Practice Address			New Billing Address		
City	State	Zip	City	State	Zip
County			County		
Phone Number	Fax		Phone Number	Fax	
() -	() -		() -	() -	

Section E. Secondary Practice Addresses For New Practice

Second Practice Name			Second Practice Tax ID		
Second Practice Address			Second Billing Address		
City	State	Zip	City	State	Zip
County			County		
Phone Number	Fax		Phone Number	Fax	
() -	() -		() -	() -	

Third Practice Name			Third Practice Tax ID		
Third Practice Address			Third Billing Address		
City	State	Zip	City	State	Zip
County			County		
Phone Number	Fax		Phone Number	Fax	
() -	() -		() -	() -	

Section F. Comments

Section G. Signature

Provider Signature _____ Provider Signature Date _____

Section H. Practice Contact Information *For questions regarding this update please list practice contact name, phone number and email address.*

Contact Name _____ Contact Phone Number _____
Contact Email Address (if applicable) _____

Please return completed form together with current copies of the following:

- Malpractice Liability Insurance Face Sheet \$1,000,000/\$3,000,000 minimum requirement.
- W-9 Tax Form, for each practice if using multiple Tax ID numbers.

Forms May Be Returned In One Of The Following Ways

Mail To: HealthSpan, Inc. Attention: Provider Relations, 225 Pictoria Drive, Suite 320, Cincinnati, Ohio 45246

Or

Fax To: (513) 551-1449

Or

Via Email @ _____