# PROVIDER UPDATE FORM

BEHAVIORAL HEALTH SYSTEMS

*Date*

**Reason for Update:**

- ☐ I have changed my legal name (copy of updated license with new name attached).
- ☐ I have obtained a new Tax ID # (copy of confirmation letter from IRS attached).
- ☐ I have changed groups/practices.
- ☐ I have added/changed location(s) with the same group/practice.
- ☐ My group/practice has changed names/Tax ID # (copy of confirmation letter from IRS attached).
- ☐ Temporary change to providing telehealth services only.
- ☐ Other:

*Provider Name* | *Date of Birth* | *Current Tax ID #*

*Group/Practice Name*

*Email Address* | *Provider NPI#*

*Telephone* | *Fax* | *Group NPI#*

*Current Primary Office Address*

*Current Mailing Address ~* ☐ *Check Here if Same as Primary Office Address*

*Current Payment Address ~* ☐ *Check Here if Same as Primary Office Address*

*If the Tax ID # above is new, under what number were you previously filing?* _____

*If the Current Primary address above is new, what address is it replacing?*

*Please provide the address(es) of any other group/practice locations (attach sheet, if necessary):*

*At what hospital(s) do you have privileges?* _____

*If you submit claims electronically, which clearinghouse do you use?* _____

*Form Completed by:* _____ *Effective Date of Change:* _____ SUBMIT