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PROVIDER INFORMATION – CHANGE FORM

Please print and return completed form to the network no less than 30 days prior to the change. Please call the network or submit a **NETWORK PARTICIPTION – REQUEST FORM** if your practice is adding a new practitioner to your group contract.

Today's Date: _____ Requested Change Effective Date _____

Requesters Name _____

Ph # _____ Fax # _____

Practice Name _____

Tax ID # _____ NPI # _____

TYPE OF CHANGE REQUESTED

- Billing Address Change
- Primary Address Change
- Add New Practice Location
- Delete Practice Location
- TAX ID # Change– include a W-9 form
- Close Practice to New Patients
- Open Practice to New Patients
- Terminate Network Participation– include reason for request to terminate participation
- Other

EXPLAIN REQUESTED CHANGE:
