



1102 S. Hillside / Wichita, KS 67211  
 1-800-801-9772 / Fax 316-683-6255 / www.ProviDRsCare.Net

## Provider or Practice Changes

Please update the provider's or practice information in the appropriate field. If you would like to update entire practice group, please contact ProviDRs Care at the information provided below.

Indicate Changes Being Submitted			
<input type="checkbox"/> Practice Information (Complete sections 1, 2, 5)	<b>Effective Date</b> _____	<input type="checkbox"/> Billing Information (Complete sections 1, 2, 5)	<b>Effective Date</b> _____
<input type="checkbox"/> Additional Location (Complete Sections 1, 3, 5)	_____	<input type="checkbox"/> Termination (Complete section 1, 4, 5)	_____
Specify documents included: <input type="checkbox"/> W-9 <input type="checkbox"/> Provider Roster <input type="checkbox"/> Other _____			

1. Provider or Practice Information	
Provider Name (Last, First) or Practice Name	
NPI#	Tax ID #
Provider Specialty <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Both <input type="checkbox"/> Hospitalist Only <input type="checkbox"/> Mid-Level	
Provider (Last, First) or Practice Name Change	
Provider Specialty Change:	

2. Address Information					
Old Location Address			New Location Address		
Practice Name			Practice Name		
Tax ID	NPI		Tax ID	NPI	
Street Address			Street Address		
City	State	Zip Code	City	State	Zip Code
Phone Number		Fax Number	Phone Number		Fax Number
Old Mailing Address			New Mailing Address		
Street Address			Street Address		
City			City		
State	Zip Code		State	Zip Code	

Phone Number		Fax Number		Phone Number		Fax Number	
<b>Old Billing Address</b>				<b>New Billing Address</b>			
Billing Name				Billing Name			
Tax ID				Tax ID			
Street Address				Street Address			
City		State	Zip Code	City		State	Zip Code
Phone Number		Fax Number		Phone Number		Fax Number	

<b>3. Additional Location</b>							
<b>Additional Location Address</b>				<b>Additional Location Billing Address</b>			
Practice Name				Practice Name			
Tax ID		NPI		Tax ID		NPI	
Street Address				Street Address			
City		State	Zip Code	City		State	Zip Code
Phone Number		Fax Number		Phone Number		Fax Number	

<b>4. Termination</b>	
Please check only one box:	
<input type="checkbox"/> Resigned	<input type="checkbox"/> Provider Sanctioned
<input type="checkbox"/> Retired	<input type="checkbox"/> Sabbatical
<input type="checkbox"/> Deceased	<input type="checkbox"/> Provider Transferred to (group name) _____
<input type="checkbox"/> Moved out-of-state	<input type="checkbox"/> Other _____
<input type="checkbox"/> Practice Closed	

<b>5. Contact Person Submitting Information</b>	
Name	Title
Phone	Fax
Email	

**Please send forms to:**

Email: [ProviderRelations@ProviDRsCare.net](mailto:ProviderRelations@ProviDRsCare.net)

**or**

Fax: (316) 683-6255

**Contact Information:**

Phone: (800) 801-9772