Provider or Practice Changes

WPPA, INC. ProviDRs Care

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

Indicate Changes Being Submitted

	Effective Date		Effective Date
☐ Practice Information (Complete sections 1,2, 5)		☐ Billing Information (Complete sections 1, 2, 5)	
☐ New Location (Complete Sections 1, 2, 5)		☐ Termination (Complete section 1, 4, 5)	

Specify documents included: ☐ W-9 ☐ Provider Roster ☐ Other _____

* Use a separate change form for each Billing NPI Number and/or Tax ID Number applicable to your request.

1. Provider or Practice Information

Provider Name (Last, First) or Practice Name		Practice Website
NPI Number	Tax ID Number	Medicare Number
Provider (Last, First) or Practice Name 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	Office Hours
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

Old Billing Address			New Billing Address		
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	

Clear Form

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

3. Additional Location

Additional Location Address			Additional Location Billing 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	

4. Termination

☐ Terminate Solo Provider

Provider Name	Provider NPI Number	Term Date
Reason for Termination		

☐ Terminate provider(s) from the group at all locations (submit attachment if necessary):

Provider Name	Provider NPI Number	Term Date
Reason for Termination		
Provider Name	Provider NPI Number	Term Date
Reason for Termination		

☐ Terminate provider(s) at the following locations only (submit attachment if necessary):

Provider Name	Provider NPI Number	Term Date
Reason for Termination		
Practice location addresses applicable to provider's term request		
Provider Name	Provider NPI Number	Term Date
Reason for Termination		
Practice location addresses applicable to provider's term request		

☐ Terminate the entire group, to include all locations and all professionals tied to group

5. Contact Person Submitting Information

Name	Title	
Phone	Fax	Email

Please send completed forms to the email or fax number below:

Email: ProviderRelations@ProviDRsCare.net
Fax: (316) 683-6255
Phone: (800) 801-9772, opt. 4, opt. 3

Clear Form