Provider Update Form

Complete all relevant fields for a change/update pertaining to a specific Provider. Please email this completed form to **provider-rosters@mhc.coop**

***** Indicates this information is required to complete this request.

Provider Update

What type of provider update are you requesting?

☐ Provider Name Change ☐ Additional Practice Location Address

Effective Date of Change*____

Group Name*____

Group Tax ID*___________ **Group NPI*** _________ **Individual NPI***______________

Provider Name*____

New Name (if Applicable) ____

Provider Gender*____

Email ________________________________ Phone*____________________

Additional Practice Location Address ______________________________________

City ______________________ State ______________ Zip ______________

Billing Address*____

City ______________________ State ______________ Zip ______________

Practice Phone*____

Practice Update Form

Complete all relevant fields for applicable practice updates. Please list any associated provider(s) and NPI number(s) that must be included under the change. **You may include a roster of providers with this form.** Please email this completed form to provider-rosters@mhc.coop.

* Indicates this information is required to complete this request.

Practice Update

What type of practice update are you requesting?

☐ Add Group NPI (Type 2 NPI)
☐ Add Additional Practice Location Address
☐ Change Existing Practice Name
☐ Change Existing Practice Address
☐ Remove Practice Location Address

Effective Date of Change* ______________________________

Group Tax ID* ____________________ **Group NPI*** ____________________

New Group NPI(s) (if applicable) ______________________________

Existing Practice Location Name*______________________________
(For Patient Visits and Directory Listing)

New Practice Name (if applicable) ______________________________

Associated Provider Name____________________**NPI** ____________________
(Applicable if affiliated with new location(s). If multiple providers, please include a roster)

Email ____________________ Fax____________________

Current Physical Address ______________________________

Phone ____________________ Fax____________________

New Physical Address (if applicable) ______________________________

Phone* ____________________ Fax____________________

Current Billing Address* ______________________________

Phone ____________________ Fax____________________

New Billing Address (if applicable) ____

Phone ______________________________________ Fax____________________________

Additional Practice Location Address (if applicable):

____

Phone ______________________________________ Fax____________________________

Additional Practice Location Address (if applicable):

____

Phone ______________________________________ Fax____________________________

Additional Practice Location Address (if applicable):

____

Phone ______________________________________ Fax____________________________

Additional Practice Location Address (if applicable):

____

Phone ______________________________________ Fax____________________________

Additional Practice Location Address (if applicable):

____

Phone ______________________________________ Fax____________________________

Additional Practice Location Address (if applicable):

____

Phone ______________________________________ Fax____________________________

Additional Practice Location Address (if applicable):

____

Phone ______________________________________ Fax____________________________

Additional Practice Location Address (if applicable):

____

Phone ______________________________________ Fax____________________________

Additional Practice Location Address (if applicable):

____

Phone ______________________________ Fax______________________

Additional Practice Location Address (if applicable):

____

Phone ______________________________ Fax______________________

Additional Practice Location Address (if applicable):

____

Phone ______________________________ Fax______________________