CHANGE OF INFORMATION FORM FOR FACILITY / ANCILLARY PROVIDERS

Submit completed form via email to: CHDProviderRelations@ecommunity.com

Please include the following information with this form:

* Current, completed W9 form
* Sample Claim (UB or CMS 1500) Form
* A list of all locations for your organization

Legal Business Name (LBN): _____ **d/b/a (if applicable):** _____

Current Tax ID (TIN): _____ **Organizational NPI #:** _____

EFFECTIVE DATE OF CHANGE: _____

TYPE OF CHANGE (check once for each): **FULL DETAILS OF EACH CHANGE**

Service Address Change? ☐ Yes / ☐ No _____

Billing/Pay-To Address Change? ☐ Yes / ☐ No _____

Service Address Termination? ☐ Yes / ☐ No _____

LBN and/or dba Organizational Name Change? ☐ Yes / ☐ No _____

TIN Change? ☐ Yes / ☐ No _____

Phone or Fax Number Change? ☐ Yes / ☐ No _____

PRINTED NAME & TITLE OF PERSON SUBMITTING CHANGE: _____

Additional Information/Comments:

Please complete the information below so that we can maintain current contact information for your organization.

Credentialing Contact Information:

Name: _____
Phone: _____
E-mail: _____

Contracting Contact Information:

Name: _____
Phone: _____
E-mail: _____

Authorized Official / Legal Contract Signer Information

Name: _____
Address: _____ *Title:* _____
_____
Phone: _____
E-mail: _____

Please contact Provider Relations if you have any questions (317)621-7581