Provider Demographic Change Form

Provider Name: _____

Select all that apply to the change request:

- ☐ Tax ID Number
- ☐ Group Name
- ☐ Provider Name
- ☐ Phone Number
- ☐ Fax Number
- ☐ Physical Address
- ☐ Mailing Address
- ☐ Billing/Remittance Address
- ☐ Other – Please describe change below

Previous Demographic Information:

Tax ID Number:_____ NPI Number: _____

Group Name: _____

Address (street, city, state, zip): _____

Phone Number:_____ Fax Number: _____

Primary Contact Email: _____

Subcontractor Email (for Referrals) : _____

Financial Email (EFT): _____

Contracting Email: _____

Credentialing Email: _____

New Demographic Information:

New Tax ID Number:_____(please attach a completed W-9)

New NPI Number: _____

New Group Name: _____

New Phone Number:_____New Fax Number: _____

Primary Contact Email: _____

Subcontractor Email (for Referrals) : _____

Financial Email (EFT): _____

Contracting Email: _____

Credentialing Email: _____

New Physical Address (street, city, state, zip): _____

New Mailing Address (street, city, state, zip): _____

New Billing Address (street, city, state, zip): _____

Return Completed Form to: Provider Relations at ProviderNetwork.credentialing@ihcscorp.com

Signature: _____ **Title**: _____