



Provider Demographic Change Form

Provider Name: _____

Select all that apply to the change request:

- Tax ID Number
- Phone Number
- Mailing Address
- Group Name
- Fax Number
- Billing/Remittance Address
- Provider Name
- Physical 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