QualChoice HEALTH INSURANCE

Provider/Practice Change Form

Complete and submit this form when information about your practice changes. If any of these changes result in a change to your W-9, please attach a new W-9 to this form. If submitting multiple records, complete Section I and attach roster. Use the *Provider Termination Form* to terminate a provider and re-assign members or to close a practice or practice site.

Section I. Person Completing this Form

Name	Phone No.	Email Address

Signature	Date Signed (MM/DD/YYYY)
x	

Section II. Provider Information

Provider Full Name	Name of Practice	Provider/Practice TIN No.	Provider NPI No.

Type of Practice	Phone No.	Fax No.	Email Address
☐ Individual ☐ Group			

Section III. Type of Change. Please check (✓) all that apply.

☐ **TIN** *and/or* **NPI No. Change**	**Effective Date** (MM/DD/YYYY)	
Previous TIN / Previous NPI No.	New TIN	New NPI No.

☐ **ADD Additional Address for TIN**	**Effective Date** (MM/DD/YYYY)			
Address	City	State	Zip	

☐ **Address Change**	**Effective Date** (MM/DD/YYYY)
Previous Address	New Address

☐ **Phone** *and/or* **Fax No. Change**	**Effective Date** (MM/DD/YYYY)	
Previous Phone No. / Previous Fax No.	New Phone No.	New Fax No.

☐ **Billing Address Change**	**Effective Date** (MM/DD/YYYY)
Previous Billing Address	New Billing Address

☐ **Provider Name Change**	**Effective Date** (MM/DD/YYYY)
Previous Name	New Name

☐ **Practice Name Change**	**Effective Date** (MM/DD/YYYY)
Previous Practice Name	New Practice Name

☐ **Practice closed to new patients**	**Effective Date** (MM/DD/YYYY)

☐ **Practice re-opened to new patients**	**Effective Date** (MM/DD/YYYY)

Mail | Fax | Email	**Internal Use Only**
QualChoice Attn: Provider Services P.O. Box 25610 Little Rock, AR 72221 F: 833.681.2503 E: PR@QualChoice.com	☐ Date rec'd by PR_____ Initials _____ ☐ Credentialing Required? ☐ Y ☐ N Initials _____ ☐ Date rec'd by Prov Data Team_____ Initials _____ ☐ Date QA Completed_____ Initials _____