selecthealth

Medical ❑ **Dental ❑**

Provider Change of Information Form

Provider Name _____

Individual NPI _____ Clinic/Office Name _____

PREVIOUS OFFICE INFORMATION

Please indicate one of the following: Changing Information ❑ Removing Information ❑

Physical Address _____

City _____ State _____ Zip _____

Phone # (_____)_____ Fax # (_____)_____

Billing Address _____

City _____ State _____ Zip _____

Billing Phone # (_____)_____ Billing Fax # (_____)_____

Tax I.D. _____ Current Covering Provider _____

Office Name _____ Effective Date of Change _____/_____/_____

Office Email Address _____

NEW OFFICE INFORMATION

Please indicate one of the following: Changing Information ❑ Adding Information ❑

(Only update lines with new information)

Physical Address _____

City _____ State _____ Zip _____

Phone # (_____)_____ Fax # (_____)_____

Billing Address _____

City _____ State _____ Zip _____

Billing Phone # (_____)_____ Billing Fax # (_____)_____

Tax I.D. _____ W-9 Attached: Yes❑ No ❑ Pay to: Self ❑ Group ❑

NOTE: W-9 must be submitted if changing Tax I.D. or billing information

Office Manager Name _____ Effective Date of Change _____/_____/_____

Office Manager Email Address _____

Covering Provider (medical only) _____

Accepting new patients at this location? Commercial Yes ❑ No ❑ SelectHealth Advantage® Yes ❑ No ❑

SelectHealth Community Care® (medical only) Yes ❑ No ❑

RETURN COMPLETED FORM AND W-9 TO:

Mail:
Attn: Provider Development
SelectHealth 5381 Green St.
Murray, UT 84123

Fax:
801-442-0776

Phone:
Provider Relations Coordinator: **800-538-5054**

Email: **provider.development@selecthealth.org**