



OhioHealth Group

Credentialing Services
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Servicing: Doctors Hospital, Dublin Methodist Hospital, Grant Medical Center, Riverside Methodist Hospital, Grady Memorial Hospital, The Medical Group of Ohio, HealthReach PPO, HealthReach Preferred, OhioHealth Practice Management Services and The American Kidney Stone Management, Ltd.

Physician Office Information Change Form Instructional Sheet

Please complete the required **boxes (1-6) on the attached change form.**

Box Numbers required to be completed	Box Number 1 - Mark all applicable reasons for submitting this form	Information need to include the following
1, 2, 4, 5, 6	Adding new locations (s)	Mark this box if you are adding additional offices associated with current tax id #.
1, 2, 3, 4, 5, 6	Relocating and changing all addresses	Mark this box if you are changing an address associated with current practice. No tax id # change.
1, 2, 3, 4, 5, 6	Adding new tax id #	W-9 is required to process this change Information submitted must include primary, additional, and remit addresses for new tax id information. Information must include "effective date" <i>Please include a copy of your updated liability insurance facesheet</i>
1, 2, 3, 4, 5, 6	Change tax id # New tax id # Old tax id #	W-9 required to process Information must include primary, additional, and remit addresses for new tax id #. Information must include an "Effective date" Information must include "Effective date" of termination from old tax id # Must include practice name <i>Please include a copy of your updated liability insurance facesheet</i>
1, 2, 3, 4, 5, 6 1, 2, 6 1, 2, 3, 4, 5, 6 1, 2, 3, 6 1, 2, 3, 5, 6 1, 2, 3, 5, 6	Other	Phone, fax number, must include tax id number and addresses associated with change Physician Name Change Practice Name Change – must include a W-9 Physician Termination No longer practicing at this location Add/Change National Provider Identifier

Please note: Failure to complete this form correctly could result in processing delays, including unprocessed claims for which you would be unable to balance bill the member. Incomplete forms may be returned for additional information

PHYSICIAN OFFICE INFORMATION CHANGE FORM

Please complete **boxes 1-6** of the information below:

Box 1

- | | |
|---|--|
| <input type="checkbox"/> Adding new location(s)
<input type="checkbox"/> Relocating and changing all addresses | <input type="checkbox"/> Adding New Tax ID# (<i>must include copy of W-9</i>)
<input type="checkbox"/> Change Tax ID# (<i>must include copy of W-9</i>)
<input type="checkbox"/> Other _____ |
|---|--|

Box 2

Provider Information (Please Print)

Name of Provider: _____ Specialty: _____
Last, First, Middle Initial *Degree*

Individual NPI #: _____ Taxonomy Code: _____

Box 3

Previous Information

Practice Name (dba): _____

Address: _____ Tax ID#: _____
 _____ Group NPI #: _____

Should this record be terminated? Yes No If yes, effective Date: _____

Box 4

New Information (*Attach separate sheet for additional address)
Include a copy of your updated liability insurance facesheet

Practice Name (dba): _____ Effective Date: _____

Name on W-9 (legal name): _____ Tax ID #: _____

Address: _____ Phone: _____
Street *Ste./Bldg./etc.*
City/State/Zip *County* Fax: _____

Office Contact Person: _____ Group NPI #: _____

Physician Pager: _____ Physician Cell Phone: _____ Answering Service: _____

List Address only used for billing below.

Billing Address: _____ Phone: _____
Street *Ste./Bldg./etc.*
City/State/Zip *County* Fax: _____

Billing Contact Person: _____

Box 5

List all physicians currently in your practice that are affected by this change: _____

Box 6

Form Completed By: _____ Phone # _____ Date _____