

Address Changes — Please complete the following form by using the instructions listed below.

Type of Address Change	Areas that need to be completed on the attached form
Adding new location(s) to an existing Tax ID #	1,2,4,5,6,7
No Tax ID # change but relocating and changing all addresses with a current practice	1,2,3,4,5,6,7
<p><b>Adding an Additional Tax ID #</b></p> <ul style="list-style-type: none"> <li>+ W-9 is required to process this change</li> <li>+ Information submitted must include primary, additional, and remit addresses for new tax ID information.</li> <li>+ All addresses must include an “effective date”</li> <li>+ Please include a copy of the provider’s updated liability insurance face sheet (for credentialing purposes)</li> </ul>	1,2,4,5,6,7
<p><b>CHANGING A TAX ID #</b></p> <p><b>Leaving a current TAX ID and starting with another TAX ID</b></p> <ul style="list-style-type: none"> <li>+ Documentation of a W-9 form must be sent</li> <li>+ Information must include primary, additional, and remit addresses for new tax id #.</li> <li>+ Information must include an “Effective date”</li> </ul> <p><b>Changing your existing TAX ID to a new TAX ID</b></p> <ul style="list-style-type: none"> <li>+ Information must include “effective date” of termination from old tax id #</li> <li>+ Must include practice name</li> <li>+ Please include a copy of your updated liability insurance face sheet (for credentialing purposes)</li> </ul>	1,2,3,4,5,6,7
<p><b>OTHER CHANGES</b></p> <p><b>Changes to phone and/or fax number(s)</b></p> <ul style="list-style-type: none"> <li>+ Please document tax ID # and specific addresses that are associated with the change</li> </ul> <p><b>Provider name change</b></p> <ul style="list-style-type: none"> <li>+ The provider’s name must match the full name of his/her Ohio state license</li> </ul> <p><b>Practice name change — must include a W-9</b></p> <p><b>Provider Termination</b></p> <p><b>No longer practicing at a specific location</b></p>	<p>1,2,4,7</p> <p>1,2</p> <p>1,3,4,7</p> <p>1,2,3,</p> <p>1,2,3,7</p>

**Please submit the completed form to OhioHealth Group via email:**  
 ProviderChanges@OhioHealthGroup.com or via fax 614-566-0401.

Please direct questions regarding this form to ProviderChanges@OhioHealthGroup.com.



Please note: Failure to complete this form correctly will result in processing delays which could affect the collection of claims.

## Area 1

### Please indicate the type of change:

- |  |  |
|--|--|
| <input type="checkbox"/> Adding a new location(s) to an existing Practice/Tax ID # | <input type="checkbox"/> Provider name change                                      |
| <input type="checkbox"/> Relocating and changing all addresses                     | <input type="checkbox"/> Adding a new Tax ID # ( <b>MUST include copy of W-9</b> ) |
| <input type="checkbox"/> No longer practicing at an address                        | <input type="checkbox"/> Change Tax ID# ( <b>MUST include copy of W-9</b> )        |
| <input type="checkbox"/> Provider termination                                      | <input type="checkbox"/> Practice name change ( <b>MUST include copy of W-9</b> )  |
| <input type="checkbox"/> Change to a contact number (phone, fax, pager, etc.)      | <input type="checkbox"/> Change directory status or accepting new patients         |

## Area 2

### Provider Information (Please Print)

Name of Provider: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Last, First, Middle Initial Degree

Individual NPI #: \_\_\_\_\_ Taxonomy Code: \_\_\_\_\_ Email: \_\_\_\_\_

## Area 3

### Previous Information

Practice Name (dba): \_\_\_\_\_

Address: \_\_\_\_\_ Tax ID #: \_\_\_\_\_

Address 2: \_\_\_\_\_ Group NPI #: \_\_\_\_\_

Should this record be terminated for this provider?  YES  NO If yes, Term Date: \_\_\_\_\_

## Area 4

### New Information (\*Attach a separate sheet for additional addresses)

Include a copy of your updated liability insurance fact sheet

Practice Name (dba): \_\_\_\_\_ Effective Date: \_\_\_\_\_

Name on W-9 (legal name): \_\_\_\_\_

Address: \_\_\_\_\_  
Street Ste./Bldg./etc. City/State/Zip County

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Tax ID #: \_\_\_\_\_

Office Contact Person: \_\_\_\_\_ Group NPI #: \_\_\_\_\_

Office Contact Email: \_\_\_\_\_

Provider's Pager: \_\_\_\_\_ Provider's Cellphone: \_\_\_\_\_ Answering Service: \_\_\_\_\_

Is this considered to be your primary address?  YES  NO

Is the provider accepting new patients at this address?  YES  NO

Should this address be publicized in patient directories?

(If not, it will be labeled as "silent")  YES  NO



**Area 5**

**Billing Address (where payments will be sent):**

Remit Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
*Street Ste./Bldg./etc.*

\_\_\_\_\_ Fax #: \_\_\_\_\_  
*City/State/ZIP County*

Billing Contact Person: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Area 6**

**Preferred Mailing Address for Credentialing Correspondence:**

Mailing Address: \_\_\_\_\_ Contact: \_\_\_\_\_  
*Street Ste./Bldg./etc.*

\_\_\_\_\_ Phone #: \_\_\_\_\_  
*City/State/ZIP County*

Email Address: \_\_\_\_\_

**Area 7**

List all other providers who are currently in the practice and affected by this change.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

