Health PLUS+

Provider Address Update Form

Please complete the following, indicating what information needs updated/added.
Please provide a current W-9 and Certificate of Insurance

Provider Name: _____

Group Name: _____

Effective Date of Change: _____

❑ **Change to new information below or** ❑ **Add an additional location** ❑ **Remove location**

Practice Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Office Fax: _____

Office Manager: _____

E-mail: _____

FEIN: _____

❑ **Change to new information below** ❑ **Remove billing location**

Billing Address: _____

City: _____ State: _____ Zip: _____

Billing Phone: _____ Billing Fax: _____

Billing Manager: _____

E-mail: _____

FEIN: _____

❑ **Change to new information below**

Credentialing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Billing Fax: _____

Credentialing Manager: _____

E-mail: _____