UnityPoint Health PLUS+

Provider Address Change Form

Please complete the following, indicating which information to change, and fax to UnityPoint Health Plus Provider Relations at (309) 999-5652.

Provider Name(s): ______________________________

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Group Name: ______________________________

Effective Date of Change: ______________________________

☐ **Change to new information below or** ☐ **Add new secondary location**

Practice Address: ______________________________

City: ______________ State: ____________ Zip: ____________

Office Phone: ______________ Office Fax: ______________

Office Manager: ______________________________

E-mail: ______________________________

☐ **Change to new information below**

Billing Address: ______________________________

City: ______________ State: ____________ Zip: ____________

Billing Phone: ______________ Billing Fax: ______________

Billing Manager: ______________________________

E-mail: ______________________________

FEIN: ______________________________

(If reporting new FEIN, attach a completed Form W-9)

☐ **Change to new information below**

Credentialing Address: ______________________________

City: ______________ State: ____________ Zip: ____________

Phone: ______________ Billing Fax: ______________

Credentialing Manager: ______________________________

E-mail: ______________________________