UnityPoint Health PLUS+

Provider Practice Change Form

If you are currently participating in Health Plus and are leaving your current group to join a new group, please complete the following and fax to Health Plus Provider Relations at (309) 999-5652

Provider Name: ______________________________

Effective Date of Change: ______________________________

☐ **Change to new information below**

Group Name: ______________________________

Practice Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Office Phone: ______________ Office Fax: ______________

Office Manager: ______________________________

E-mail: ______________________________

Billing Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Billing Phone: ______________ Billing Fax: ______________

Billing Manager: ______________________________

E-mail: ______________________________

FEIN: ______________________________

Credentialing Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Phone: ______________ Billing Fax: ______________

Credentialing Manager: ______________________________

E-mail: ______________________________

You must also attach:

☐ Current certificate of liability

☐ Form W-9