

Northwell Health IPA

PROVIDER DATA CHANGE FORM

600 Community Drive, Suite 402, Manhasset, New York 11030

Phone: (800) 381-6140 Fax: (516) 321-8077 Email: NorthwellHealthIPA@northwell.edu

SECTION 1: PROVIDER CONTACT INFORMATION

Today's Date: ___/___/___

Practice Name: _____

Provider Name: _____

Contact Person: _____

Provider Specialty: _____

Contact Phone: _____

Provider NPI: _____

Contact Email: _____

Group NPI: _____

Authorizer: _____

SECTION 2: DEMOGRAPHIC CHANGE(S) - Complete all sections that apply. If there is more than one location, please complete additional forms.

Service Address to Add

Practice Name _____

Tel: _____

Fax: _____

Tax ID: _____

Effective Date: ___/___/___

Is this the Primary Service Address? Yes No

Office Hours

Mon: _____ Tue: _____ Wed: _____

Thu: _____ Fri: _____ Sat: _____ Sun: _____

Service Address to Terminate

Practice Name _____

Tel: _____

Fax: _____

Tax ID: _____

Termination Date: ___/___/___

Billing Address to Add

Practice Name _____

Tel: _____

Fax: _____

Tax ID: _____

Effective Date: ___/___/___

Billing Address to Terminate

Practice Name _____

Tel: _____

Fax: _____

Tax ID: _____

Termination Date: ___/___/___

Northwell Health IPA

PROVIDER DATA CHANGE FORM

600 Community Drive, Suite 402, Manhasset, New York 11030

Phone: (800) 381-6140 Fax: (516) 321-8077 Email: NorthwellHealthIPA@northwell.edu

SECTION 3: TAX ID CHANGES - A W9 form must accompany all requests for Tax ID changes and are subject to Northwell Health IPA approval and may require new or additional contracting.

Tax ID to Requesting to add	Tax ID to Terminate
Tax ID _____ Practice Name _____ Effective Date: __/__/____	Tax ID _____ Practice Name _____ Termination Date: __/__/____

SECTION 4: OTHER UPDATES / CHANGES

1) _____
2) _____
3) _____
4) _____
5) _____

**Please allow 10-14 business days to process your request from the date of receipt.
Tax ID updates will NOT be processed without a completed W9 form.**