

Clinical Integration Network IPA

PROVIDER DATA CHANGE FORM

600 Community Drive, Suite 402, Manhasset, New York 11030
Phone: (800) 381-6140 Fax: (516) 321-8077 Website: ciipa.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: _____ Authorized Signature: _____

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: ___/___/___

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: ___/___/___

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

Tax ID 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.**