



**CENTERS PLAN
FOR HEALTHY
LIVING**

75 Vanderbilt Ave Suite 700 Staten Island NY 10304



1-844-CPHL-CARES



www.centersplan.com

PROVIDER DEMOGRAPHIC CHANGE REQUEST FORM

Current Provider Information

Provider/Organization Name: _____ Tax Id: _____

Specialty: _____ NPI: _____

Provider Change Information:

This change affects:

Individual provider Group Practice Institution/Facility Date change will take effect: _____

Type of Change: (Please check all that apply)

<input type="checkbox"/> Add TIN	<input type="checkbox"/> Change Billing Address	<input type="checkbox"/> Change Name (Group or Physician)
<input type="checkbox"/> Deactivate TIN	<input type="checkbox"/> Add Service Address	<input type="checkbox"/> Change or Add Hospital Affiliation
<input type="checkbox"/> Change TIN	<input type="checkbox"/> Delete Service Address	<input type="checkbox"/> Change Specialty: _____

New Demographic Information

New Service Information: (If more than one location, attach additional sheet)

Primary Service Location? Yes / No

Individual name: _____

Group name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone: _____ Fax: _____

Tax ID: _____

New Billing Information: (W-9 form must be submitted with all tax ID updates)

Name: _____ (As shown on your income tax return)
Address: _____
City: _____ State: _____ Zip code: _____
Telephone: _____ Fax: _____
Tax ID: _____

Old Demographic Information

Old Service Information: (If more than one location, attach additional sheet)

Primary Service Location? Yes / No
Individual name: _____
Group name: _____
Address: _____
City: _____ State: _____ Zip code: _____
Telephone: _____ Fax: _____
Tax ID: _____

Old Billing Information: (W-9 form must be submitted with all tax ID updates)

Name: _____ (As shown on your income tax return)
Address: _____
City: _____ State: _____ Zip code: _____
Telephone: _____ Fax: _____
Tax ID: _____

Print name and title of authorized signature: _____

Authorized signature: X _____ **Date:** _____

Telephone: _____ **Email:** _____

Please mail, fax or email completed form with additional documentation to:

Centers Plan

Attn: Provider Services Department
75 Vanderbilt Avenue
Suite 600
Staten Island, NY 10304

(Fax) 718-581-5562

Email: Providerservices@centersplan.com

Please allow up to 15 business days to process your request.
Tax ID update cannot be processed without a properly completed W-9 form