



**PROVIDER CHANGE FORM**

Current Group/Practice Name: \_\_\_\_\_

Current Provider Name: \_\_\_\_\_

Individual Provider NPI: \_\_\_\_\_ Group NPI: \_\_\_\_\_

Change Group/Practice Name to: \_\_\_\_\_

Change Provider(s) Name to: \_\_\_\_\_  
[Please provide supporting documentation; i.e., current license and/or other proof of name change]

Add this Physician to your group: \_\_\_\_\_  
[

Name of Provider leaving the Practice: \_\_\_\_\_  
Reason Provider is leaving the practice: \_\_\_\_\_  
Forwarding address: \_\_\_\_\_ Forwarding phone: \_\_\_\_\_

Change Practice Location Address/Phone/Fax:  
From (current): \_\_\_\_\_  
To (provide new information): \_\_\_\_\_

Delete this Practice Address/Phone/Fax: \_\_\_\_\_

Add this Practice Address/Phone/Fax to this Provider: \_\_\_\_\_

***Any changes related to billing information (Name, Address, Tax ID) must be accompanied by a completed W9 form***

Change Billing Address/Phone/Fax:  
From (current): \_\_\_\_\_  
To (provide new information): \_\_\_\_\_

Add this Billing Address/Phone/Fax to this Provider: \_\_\_\_\_

Change Tax ID Number: From (current): \_\_\_\_\_ To (provide new Tax ID#): \_\_\_\_\_

Add Tax ID Number: \_\_\_\_\_

Board Certification completion: \_\_\_\_\_  Specialty Change/Correction: \_\_\_\_\_

Other [detail]: \_\_\_\_\_

PCP's Only - Panel Status:  Open  Closed  Existing Patients Only

Effective Date of Change(s): \_\_\_\_\_

\_\_\_\_\_  
Print name of person completing this form

\_\_\_\_\_  
Signature of person completing this form

\_\_\_\_\_  
Title of person completing this form

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

Please send completed form to Network Management/Provider Relations Department by email, fax, or mail.  
Email: [usfamily@svcmcnyc.org](mailto:usfamily@svcmcnyc.org) Fax: 212-356-4923  
Mail: USFHP - Network Management/Provider Relations Department  
450 West 33<sup>rd</sup> Street, 12<sup>th</sup> floor, New York, New York 10001