OhioHealthy

Address Changes — Please complete the following form by using the instructions listed below.

Type of Address Change	Areas that need to be completed on the attached form
Adding new location(s) to an existing Tax ID #	1,2,4,5,6,7
No Tax ID # change but relocating and changing all addresses with a current practice	1,2,3,4,5,6,7
Adding an Additional Tax ID # + W-9 is required to process this change + Information submitted must include primary, additional, and remit addresses for new tax ID information. + All addresses must include an "efective date" + Please include a copy of the provider's updated liability insurance face sheet (for credentialing purposes)	1,2,4,5,6,7
CHANGING A TAX ID # **Leaving a current TAX ID and starting with another TAX ID** + Documentation of a W-9 form must be sent + Information must include primary, additional, and remit addresses for new tax id #. + Information must include an "Effective date" **Changing your existing TAX ID to a new TAX ID** + Information must include "efective date" of termination from old tax id # + Must include practice name + Please include a copy of your updated liability insurance face sheet (for credentialing purposes)	1,2,3,4,5,6,7
OTHER CHANGES **Changes to phone and/or fax number(s)** + Please document tax ID # and specific addresses that are associated with the change **Provider name change** + The provider's name must match the full name of his/her Ohio state license **Practice name change — must include a W-9** **Provider Termination** **No longer practicing at a specific location**	 1,2,4,7 1,2 1,3,4,7 1,2,3, 1,2,3,7

Please submit the completed form to the OhioHealthy via email:

OH-providerchanges@ohiohealth.com or via fax 614-566-0401.

Please direct questions regarding this form to **OH-providerchanges@ohiohealth.com**.

Please note: Failure to complete this form correctly will result in processing delays which could affect the collection of claims.

Area 1 Please indicate the type of change:

- □ Adding a new location(s) to an existing Practice/Tax ID #
- □ Relocating and changing all addresses
- □ No longer practicing at an address
- □ Provider termination
- □ Change to a contact number (phone, fax, pager, etc.)
- □ Provider name change
- □ Adding a new ax ID # (MUST include copy of W-9)
- □ Change Tax ID# (MUST include copy of W-9)
- □ Practice name change (MUST include copy of W-9)
- □ Change directory status or accepting new patients

Area 2 Provider Information (Please Print)

Name of Provider:_____ Specialty: _____

Individual NPI#:_____ Taxonomy Code:_____ Email: _____

Area 3 Previous Information

Practice Name (dba): _____

Address:_____ Tax ID #: _____

Address 2:_____ Group NPI #: _____

Should this record be terminated for this provider? □ YES □ NO If yes, Term Date: _____

Area 4 New Information (*Attach a separate sheet for additional addresses)

Practice Name (dba): _____ Effective Date: _____

Name on W-9 (legal name): _____

Address:_____

Phone #:_____ Fax #:_____ Tax ID #: _____

Office Contact Person:_____ Group NPI #: _____

Office Contact Email: _____

Provider's Cellphone:_____ Answering Service: _____

Provider Email:_____

Is this considered to be your primary address? □ YES □ NO

Is the provider accepting new patients at this address? □ YES □ NO

Should this address be publicized in patient directories?
(If not, it will be labeled as "silent") □ YES □ NO

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Area 5 Billing Address (where payments will be sent):

Remit Address:_____ Phone #: _____

_____ Fax #: _____

Billing Contact Person:_____ Email Address: _____

Area 6 Preferred Mailing Address for Credentialing Correspondence:

Mailing Address:_____ Phone #: _____

_____ Fax #: _____

Email Address: _____

Area 7 List all other providers who are currently in the practice and afected by this change.

_____

_____

_____

_____

Advanced Practice Providers are required to supply updated collaborating physician information. Please note below your collaborating physician(s):

_____

_____

_____

_____

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