# Provider Change of Data Form

Please use this form to indicate changes in your data. Complete applicable sections only. Please mail or fax (501-378-2465) the completed form with supporting documents to: Provider Enrollment, PO Box 2181, Little Rock, AR 72203. If payment to a clinic or group is required, please complete an ***Authorization for Clinic Billing*** form. Practitioners wishing to use an Employer Identification Number (EIN) for payment must submit verification of EIN (Letter *147C*, *CP 575 E*, or tax coupon *8109-C*). Please type or print.

Name _____ NPI _____
(First, MI, Last) (Attach copy of NPI verification from NPPES)

Doing Business As _____ ABCBS# _____

Change Effective Date _____ Medical Records Fax # _____

Date of Birth _____ Degree _____ Male ___ Female ___ US Citizen? ___ SSN _____

Specialty _____ Secondary Specialty _____

Primary Language English Secondary Languages _____

Handicapped Accessible? _____ TTY Services? _____

AR License/Certification # _____ Issue Date _____ Expiration Date _____
(Attach copy of license)

Other License/Certification # _____ ST _____ Issue Date _____ Expiration Date _____
(Attach copy)

DEA # _____ ST _____ Issue Date _____ Expiration Date _____

Email Address _____

Primary Contact Person _____ Title _____

**PHYSICAL LOCATION INFORMATION** - Must have a street address – PO Boxes are not acceptable

Practice Location Address _____

_____

Phone # to be used for Patient Appointments _____ Fax # _____

**CORRESPONDENCE INFORMATION** - For notifications, newsletters, credentialing updates, etc.

Correspondence Address _____

_____

Correspondence Phone # _____ Fax # _____

**PAYMENT INFORMATION** - If payment to a clinic or group is required, please complete the *Authorization for Clinic Billing* form.

Are you incorporated? _____ Payment EIN _____
(Attach IRS verification of EIN)

Payment Name _____

Payment Address _____

_____

Payment Phone # _____ Payment Fax # _____

_____
Print Name of Individual Practitioner

Signature _____ Date _____
(Individual Practitioner- NO STAMPS OR DIGITAL SIGNATURES)



Clear Form