HealthChoice

IDRS Oklahoma Department of Rehabilitation Services

DOC Department of Corrections Oklahoma

NETWORK FACILITY CHANGE FORM

Facility Name: _____ Specialty: _____

New Physical Address

_____

_____

_____

Phone: _____

Fax: _____

Contact Person: _____

Email Address: _____

New Billing Address

(List any additional billing addresses on a separate sheet)

_____

_____

_____

Phone: _____

Fax: _____

Contact Person: _____

Email Address: _____

Former Physical Address

(Required if changing address)

_____

_____

_____

Phone: _____

Date this address terminated: _____

Contact Name (Print): _____

Authorized Signature: _____

Phone: _____

Date: _____

Failure to provide the requested information could result in a delay of payment and/or non-payment of claims

New Mailing Address

(List any additional physical addresses on a separate sheet)

_____

_____

_____

Phone: _____

Fax: _____

Contact Person: _____

Email Address: _____

Tax ID Number (TIN)

(Attach a completed W-9 Form)

Tax ID Number: _____

NPI Number: _____

Did this TIN/NPI change with new address? Yes ☐ No ☐

If yes, previous TIN: _____

If yes, previous NPI: _____

Effective date of this new address: _____

Is this an additional location? Yes ☐ No ☐

If no, please list the former address below:

Former Billing Address

_____

_____

_____

Phone: _____

Date this address terminated: _____

**** Office Mailing Address, if listed, will be utilized for all legal contractual notices as defined in section 11.1 of the facility contracts and for all credentialing notices/documents. Claims Payment Address, if listed, will be used for all payment related notices/documents. ****

Attach a completed W-9 Form for each TIN, Medicare Certification and/or Accreditation, if applicable.

Return fax numbers: 405-717-8977 or 405-717-8702
Email addresses: EGID.NetworkManagement@omes.ok.gov or EGID.NetworkNews@omes.ok.gov