HealthChoice | DRS Oklahoma Department of Rehabilitation Services | DOC Department of Corrections Oklahoma

NETWORK PROVIDER CHANGE FORM

Name: ____
(Last) (First) (Middle) (License Type)

NPI Number: ______________________________________

Primary Specialty: ________________________________

Secondary Specialty: ______________________________

New Physical Address

Office Name: ______________________________________

Office Address: ____________________________________

____
(City) (State) (Zip)

Phone: ____

Fax: ____

Contact Person: ___________________________________

Email Address: ____________________________________

New Billing Address

(List any additional billing addresses on a separate sheet)

Billing Name: _____________________________________

Billing Address: ___________________________________

____
(City) (State) (Zip)

Phone: ____

Fax: ____

Contact Person: ___________________________________

Email Address: ____________________________________

Former Physical Address

(Required if changing address)

Office Name: ______________________________________

Office Address: ____________________________________

____
(City) (State) (Zip)

Phone: ____

Contact Name (Print): ______________________________

Authorized Signature: ______________________________

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

Office Mailing Address, if listed, will be utilized for all legal contractual notices as defined in section 12.2 of the provider contracts and for all credentialing notices/documents. Claims Payment Address, if listed, will be used for all payment related notices/documents.

New Mailing Address

(List any additional physical addresses on a separate sheet)

Office Name: ______________________________________

Office Address: ____________________________________

____
(City) (State) (Zip)

Phone: ____

Fax: ____

Contact Person: ___________________________________

Email Address: ____________________________________

Tax ID Number (TIN)

(Attach a completed Form W9)

Tax ID Number: ____________________________________

Did this TIN change? Yes ☐ No ☐

If yes, previous TIN: _______________________________

Effective date of this change: _______________________

Former Billing Address

(Required if changing address)

Billing Name: _____________________________________

Billing Address: ___________________________________

____
(City) (State) (Zip)

Phone: ____

Phone: ____

Date: ____

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

Updated 04/11/2018