1199SEIU Benefit Funds

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PROVIDER DEMOGRAPHIC INFORMATION CHANGE REQUEST FORM

Please type or print legibly to avoid processing delays or complete online.

☐ **Participating provider** ☐ **Non-participating provider**

CURRENT PROVIDER INFORMATION

PROVIDER NAME _____ MAIN EMAIL _____ PATIENT-FACING EMAIL _____

SPECIALTY _____ AREA OF INTEREST _____ NPI _____ TAX ID _____

Board certified: ☐ Yes ☐ No

Does the office meet ADA accessibility requirements? ☐ Yes ☐ No

PROVIDER CHANGE INFORMATION

This change affects:

☐ Group practice ☐ Individual provider ☐ Institution/Facility Date change will take effect: _____
DATE (MM/DD/YYYY)

Type of Change (Please check all that apply)

☐ Add TIN
☐ Deactivate TIN
☐ Change TIN
☐ Add billing address
☐ Change billing address
☐ Add service address
☐ Delete service address
☐ Change service address
☐ Add provider languages spoken: _____
☐ Add email: _____
☐ Change email: _____
☐ Add staff language spoken: _____
☐ Change name (group or physician): _____
☐ Change or add hospital affiliation: _____
☐ Add specialty: _____
☐ Other: _____
☐ Delete provider language: _____
☐ Accepting new patients? ☐ Yes ☐ No
☐ Add office hours: _____
☐ Delete staff language: _____

NEW DEMOGRAPHIC INFORMATION

New Service Information
(If more than one location, attach an additional form for each location)

Primary service location? ☐ Yes ☐ No

INDIVIDUAL NAME _____

GROUP NAME/GROUP NPI _____ TAX ID _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____ FAX _____

New Billing Information
(Form W-9 must be submitted with all tax ID updates)

NAME (AS SHOWN ON YOUR INCOME TAX RETURN) _____

NPI _____ TAX ID _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____ FAX _____

OLD DEMOGRAPHIC INFORMATION

Old Service Information
(If more than one location, attach an additional form for each location)

INDIVIDUAL NAME

GROUP NAME/GROUP NPI | TAX ID

ADDRESS

CITY | STATE | ZIP CODE

TELEPHONE | FAX

Old Billing Information

NAME (AS SHOWN ON YOUR INCOME TAX RETURN)

NPI | TAX ID

ADDRESS

CITY | STATE | ZIP CODE

TELEPHONE | FAX

PRINT NAME AND TITLE OF AUTHORIZED SIGNATURE

X

AUTHORIZED SIGNATURE | DATE (MM/DD/YYYY) | TITLE

EMAIL ADDRESS | TELEPHONE | FAX

Please fax or email completed form with additional documentation to:
Fax: (646) 473-7229 | Email: Providers@1199Funds.org
Please allow 45 days to process your request. Tax ID updates cannot be processed without a properly completed Form W-9.

INTERNAL USE ONLY

Contract Type

- ☐ Par professional: _____
- ☐ Par facility: _____
- ☐ Non-par professional: _____
- ☐ Non-par facility: _____
- ☐ Special contract: _____
- Effective date of new contract: _____
- ☐ MCHCS: _____
- Requester initial: _____