



Provider/Practice Change Form

Complete and submit this form when information about your practice changes. If any of these changes result in a change to your W-9, please attach a new W-9 to this form. If submitting multiple records, complete Section I and attach roster. Use the *Provider Termination Form* to terminate a provider and re-assign members or to close a practice or practice site.

Section I. Person Completing this Form			
Name		Phone No.	Email Address
Signature X		Date Signed (MM/DD/YYYY)	
Section II. Provider Information			
Provider Full Name		Name of Practice	Provider/Practice TIN No. Provider NPI No.
Type of Practice <input type="checkbox"/> Individual <input type="checkbox"/> Group	Phone No.	Fax No.	Email Address
Section III. Type of Change. Please check (✓) all that apply.			
<input type="checkbox"/> TIN and/or NPI No. Change		Effective Date (MM/DD/YYYY)	
Previous TIN	Previous NPI No.	New TIN	New NPI No.
<input type="checkbox"/> ADD Additional Address for TIN		Effective Date (MM/DD/YYYY)	
Address		City	State Zip
<input type="checkbox"/> Address Change		Effective Date (MM/DD/YYYY)	
Previous Address		New Address	
<input type="checkbox"/> Phone and/or Fax No. Change		Effective Date (MM/DD/YYYY)	
Previous Phone No.	Previous Fax No.	New Phone No.	New Fax No.
<input type="checkbox"/> Billing Address Change		Effective Date (MM/DD/YYYY)	
Previous Billing Address		New Billing Address	
<input type="checkbox"/> Provider Name Change		Effective Date (MM/DD/YYYY)	
Previous Name		New Name	
<input type="checkbox"/> Practice Name Change		Effective Date (MM/DD/YYYY)	
Previous Practice Name		New Practice Name	
<input type="checkbox"/> Practice closed to new patients		Effective Date (MM/DD/YYYY)	
<input type="checkbox"/> Practice re-opened to new patients		Effective Date (MM/DD/YYYY)	
Mail Fax Email		Internal Use Only	
SoundPath Health 33820 Weyerhaeuser Way S., Ste. 200 Federal Way, WA 98001 F: 253.517.4362 E: providerrelations@soundpathhealth.com		<input type="checkbox"/> Date rec'd by PR _____ Initials _____ <input type="checkbox"/> Credentialing Required? <input type="checkbox"/> Y <input type="checkbox"/> N Initials _____ <input type="checkbox"/> Date rec'd by Prov Data Team _____ Initials _____ <input type="checkbox"/> Date QA Completed _____ Initials _____	