IMPERIAL HEALTH PLAN
OF CALIFORNIA

# Provider Demographic Information Change Request Form

Please type or print legibly to avoid processing delays.

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

## Current Provider Information

Provider name:_____ Email: _____

Specialty:_____ NPI:_____ Tax ID: _____

## Provider Change Information

This change affects:

❑ Group practice ❑ Individual provider ❑ Institution/Facility Date change will take effect:_____/_____/_____
Month Date Year

**Type of Change** (Please check all that apply)

❑ Add TIN
❑ Deactivate TIN
❑ Change TIN
❑ Add billing address
❑ Add service address
❑ Change service address
❑ Change billing address
❑ Delete service address
❑ Change name (group or physician):_____
❑ Change or add hospital affiliation:_____
❑ Add specialty:_____
❑ Other:_____

## 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:_____
Address:_____
City:_____ State:_____ Zip code:_____
Telephone: ( _____)_____
Fax: (_____)_____ Tax ID: _____

**New Billing Information:**
(W-9 form must be submitted with all Tax ID updates)
Name: (As shown on your income tax return)
_____
Address: _____
City:_____ State:_____ Zip code: _____
Telephone: ( _____) _____
Fax: (_____) _____
Tax ID: _____ NPI: _____

## Old Demographic Information

**Old Service Information:**
(If more than one location, attach an additional form for each location)
Individual name:_____
Group name:_____
Address:_____
City:_____ State:_____ Zip code: _____
Telephone: (_____)_____
Fax: (_____) _____ Tax ID: _____

**New Billing Information:**
Name: (As shown on your income tax return)
_____
Address: _____
City:_____ State:_____ Zip code: _____
Telephone: (_____) _____
Fax: (_____) _____
Tax ID: _____ NPI: _____

Print name and title of authorized signature: _____

Authorized signature: **X** _____ Date: _____

Title:_____ Email: _____

Telephone: (_____)_____ Fax: (_____) _____

**Please fax or email completed form with additional documentation to:**
Fax: (626) 205-9536 | Email: pno@imperialhealthholdings.com
**Tax ID updates cannot be processed without a properly completed W-9 Form.**

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**INTERNAL USE ONLY:** Update Completed ☐ Initials:_____ ☐ Date:_____/_____/_____