



101 SE Third Street
 Evansville, IN 47708
 Phone: 812-426-6600
 Fax: 716-541-6362

PROVIDER UPDATE FORM

Please complete the appropriate section(s) below and return the completed form to WHP Provider Services. If necessary, complete multiple forms.

PROVIDER INFORMATION (Please complete for all requests)

NAME:

_____ *First* _____ *MI* _____ *Last* _____ *Title*

Individual NPI: _____

PCP or Specialist: PCP Specialist Both

Primary Specialty: _____

Secondary Specialty(s): _____

Board Certified in: _____ Effective: _____

Board Certified in: _____ Effective: _____

Does provider wish to be listed in the WHP Provider Directory? _____

Name of person(s) whom provide call coverage: _____

Name(s) of hospital(s) where provider has privileges: _____

TERMINATING A PROVIDER (if applicable)

Termination Date: _____ Tax ID #: _____

Did provider: Retire Move out of area Other (explain) _____

ADDING A PRACTICE LOCATION (if applicable)

A copy of the following documents are **required**: W-9 and a completed claim form with patient information blackened out.

Tax ID#: _____ Grp NPI: _____

Practice Name: _____ Billing Name: _____

Address: _____ Address: _____

City, ST, ZIP: _____ City, ST, ZIP: _____

Telephone: _____ Telephone: _____

Fax: _____ Fax: _____

Office Manager: _____ Billing Office Mgr: _____

E-mail: _____ E-mail: _____

Effective Date: _____ Effective Date: _____

Which address should be used for correspondence? Practice Billing

Accepting new patients at this location? Yes No

Should this location be listed in the WHP Provider Directory? Yes No

DELETING A PRACTICE LOCATION (if applicable)

Deactivate TIN #: _____

All locations under this TIN? Yes No (If no, please complete the following information)

Practice Name: _____	Billing Name: _____
Address: _____	Address: _____
City, ST, ZIP: _____	City, ST, ZIP: _____
Telephone: _____	Telephone: _____
Fax: _____	Fax: _____
Office Manager: _____	Billing Office Mgr: _____
E-mail: _____	E-mail: _____
Termination Date: _____	Termination Date: _____

CHANGE IN PRACTICE INFORMATION (if applicable)

A copy of the following documents are **required** for the **new** location: W-9 and a completed claim form with patient information blackened out.

OLD Practice Information:

Practice Name: _____	Billing Name: _____
Address: _____	Address: _____
City, ST, ZIP: _____	City, ST, ZIP: _____
Termination Date: _____	Termination Date: _____

NEW Practice Information:

Tax ID#: _____	Grp NPI: _____
Practice Name: _____	Billing Name: _____
Address: _____	Address: _____
City, ST, ZIP: _____	City, ST, ZIP: _____
Telephone: _____	Telephone: _____
Fax: _____	Fax: _____
Office Manager: _____	Billing Office Mgr: _____
E-mail: _____	E-mail: _____
Effective Date: _____	Effective Date: _____

- Which address should be used for correspondence? Practice Billing
- Accepting new patients at this location? Yes No
- Should this location be listed in the WHP Provider Directory? Yes No