SELECT HEALTH NETWORK

PROVIDER CHANGE NOTIFICATION FORM

Please add additional information in the comments section

Information Changing	■ **Practice** ☐ **Billing** ☐ **TIN** ☐ **Other - please specify in Comment section below**		
Group NPI Number		**Group Medicaid Number Location Code**	
Specialty		**Age Limit**	☐ None ☐ 0-17 ☐ 18+ yrs ☐ 21+ yrs
List in Directory	☐ Yes ☐ No		
Hospital Based ☐ *Yes ☐ No	***By checking yes, you are stating that the provider practices solely in the hospital setting at SJHS and members are referred to the facility and not directly to the provider. Hospital based providers will not be listed in the provider directory.**		
Contact Person		**E-mail Address**	

Provider Data	**New Information**	**Previous/Current Information**	**Effective Date**
Tax ID Number			
Practitioner Name			
Practitioner E-mail			
Practice Name **Primary Location** ☐ Other ☐ **(Specify)**			
Practice Address			
City, State, Zip			
Practice Manager Phone#/E-mail address			
EMR Software/Version			
Phone Number			
Fax Number			
Office Hours			
Accepting New Patients	☐ Yes ☐ No	☐ Yes ☐ No	

Billing Data	**New Information**	**Previous/Current Information**	**Effective Date**
Billing Company			
Billing Address			
City, State, Zip			
Phone Number			
Fax Number			

Remit Data	**New Information**	**Previous/Current Information**	**Effective Date**
Remit To Name			
Remit Address			
City, State, Zip			

Provide information on the "Remit to" or "Pay to" - This information *must* match what your practice is billing in Box 33 on HCFA

Comments

314 W. Catalpa Dr., Ste. A • Mishawaka, IN 46545
Phone: (574) 283-5959 • Fax: (574) 283-5950