Area 1

☐ ?bbg_lec ÿma_rgmmlc&qgqrgl_e
Np_argGaBc - R_v
☐ Pcjma_lrabgfl_el e_gl_bbepcqqcq
☐ Imjmlrepc par_gralgbbepcqq
☐ NpmPgbccppk gl_rgml
☐ Af_lrema ml rl_sakr`&cnpf mdl_cv**
n_eccpa*, '

☐ NpmPgbcp l_kc af_lec
☐ ?bbgle v_BAGl&dKuS QRR_ gldajUs-bZ ar
☐ Af_lec R_v GBA &dKSQR glaj
☐ Np_argac l_kc af_lec &KS
U7 '
☐ Af_lec bgpcarmpw qr_rsq mp

?pc_ 1SRHSOGPSNBRO1MRT1SO*

Name of Provider: _____ Specialty: _____

Individual NPI#: _____ Taxonomy Code: _____ Email: _____

$FB 1SRTOGPSNBRO

Practice Name (dba): _____

Address: _____ Tax ID #: _____

Address 2: _____ Group NPI #: _____

Should this record be terminated for this provider? ☐YES ☐NO If yes, Term Date: _____

$FB /F GPSNBU PO UBDIBTFBSBUF IFFUGPSBEEP OBMBEESFTTFT

1SBDDF/BNF ECB _____ GGFDWFBU F _____

/BNFPOMFHBMOBNF _____

EESFTT _____

1IPOF _____ BY _____ 5BYB _____

0GDDFPOUBDUFSTPO _____ (SPV1 _____

0GDDFPOUBDUNBM _____

1SPWFSTMMPOF _____ OTESOH4FSWDF _____

1SPWFSNBM _____

IPOTEFSFEJPCFPVSBNBSBEESFTT ☐ WCQ ☐ IM

Gq rfc npmPgbuc pn __ragacrhfmgqgl_e bblpcqq= ☐ WCQ ☐ IM

Qfmsjb rf`gmqs`_jblgpahg_qrqgbc lr bgpcarmpgcq=

&Gd lmr* gr ugj jWCQc ☐ jIM`cjcb _q §qgjclr³ '

OhioHealthy

Area 5 **Billing Address (where payments will be sent):**

Remit Address:_____ Phone #: _____

_____ Fax #: _____

Billing Contact Person:_____ Email Address: _____

Area 6 **Preferred Mailing Address for Credentialing Correspondence**

Mailing Address:_____ Phone #: _____

_____ Fax #: _____

Email Address: _____

Area 7 **List all other providers who are currently in the practice and affected by this change.**

_____

_____

_____

_____

Advanced Practice Providers are required to supply updated collaborating physician information. Please note below your collaborating physician(s):

_____

_____

_____

_____

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