Address Changes — Please complete the form by using the instructions listed below.

Type of Address Change	Areas that need to be completed on the attached form
Adding new location(s) to an existing Tax ID #	1,2,4,5,6,7
No Tax ID # change but relocating and changing all addresses with a current practice	1,2,3,4,5,6,7
Adding an Additional Tax ID # + W-9 is required to process this change + Information submitted must include primary, additional, and remit addresses for new tax ID information. + All addresses must include an "effective date" + Please include a copy of the provider's updated liability insurance face sheet (for credentialing purposes)	1,2,4,5,6,7
CHANGING A TAX ID # **Leaving a current TAX ID and starting with another TAX ID** + Documentation of a W-9 form must be sent + Information must include primary, additional, and remit addresses for new tax id #. + Information must include an "effective date" **Changing your existing TAX ID to a new TAX ID** + Information must include "effective date" of termination from old tax id # + Must include practice name + Please include a copy of your updated liability insurance face sheet (for credentialing purposes)	1,2,3,4,5,6,7
OTHER CHANGES	
Changes to phone and/or fax number(s) + Please document tax ID # and specific addresses that are associated with the change	1,2,4,7
Provider name change + The provider's name must match the full name of their Ohio state license	1,2
Practice name change — must include a W-9	1,3,4,7
Provider Termination	1,2,3,
No longer practicing at a specific location	1,2,3,7

Please submit the completed form to the OhioHealthy via email:
OH-providerchanges@ohiohealth.com or via fax 614-566-0401.
Please direct questions regarding this form to OH-providerchanges@ohiohealth.com.

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Please note: Failure to complete this form correctly will result in processing delays which could affect the collection of claims.

Area 1 — Please indicate the type of change:

- □ Adding a new location(s) to an existing Practice/Tax ID #
- □ Relocating and changing all addresses
- □ No longer practicing at an address
- □ Provider termination
- □ Change to a contact number (phone, fax, pager, etc.)
- □ Provider name change
- □ Adding a new Tax ID # (MUST include copy of W-9)
- □ Change Tax ID# (MUST include copy of W-9)
- □ Practice name change (MUST include copy of W-9)
- □ Change directory status or accepting new patients

Area 2 — Provider Information (Please Print)

Name of Provider: ______________________________ Specialty: ____________________

Individual NPI#: ______________ Taxonomy Code: ____________ Email: ____________________

Area 3 — Previous Information

Practice Name (dba): ____

Address: ____ Tax ID #: ________________

Address 2: ______________________________________ Group NPI #: ______________

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

Area 4 — New Information (*Attach a separate sheet for additional addresses)

Practice Name (dba): ______________________________ Effective Date: ______________

Name on W-9 (legal name): ____

Address: ____

Phone #: ______________________ Fax #: ________________ Tax ID #: ______________

Office Contact Person: ______________________________ Group NPI #: ______________

Office Contact Email: ______________________________

Provider's Cellphone: ________________ Answering Service: ________________

Provider Email: ______________________________________

Is this considered to be your primary address? □ YES □ NO

Is the provider accepting new patients at this address? □ YES □ NO

Should this address be publicized in patient directories?
(If not, it will be labeled as "silent") □ YES □ NO

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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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