OhioHealth

PROVIDER ADDRESS CHANGES — INSTRUCTION FORM

Please complete the following form using the instructions listed below.

Type of Address Change	Areas to Complete on Attached Form	Additional Requirements / Notes
Adding new location(s) to an existing Tax ID # or to an existing Provider	1, 2, 4, 7	
Relocating and changing all addresses with a current practice and Tax ID	1, 2, 3, 4, 5, 6, 7	
Adding an Additional Tax ID # *W-9 is required to process this change*	1, 2, 4, 5, 6, 7	* Include primary, additional, and remit addresses * All addresses must have an effective date * Include a copy of updated liability insurance face sheet (for credentialing) (For an individual provider, Area 7 is not required)
Changing a Tax ID # *W-9 is required to process this change*	1, 2, 3, 4, 5, 6, 7	
Leaving a current Tax ID and starting with another Tax ID W-9 is required to process this change	1, 2, 3, 4, 5, 6, 7	* Include primary, additional, and remit addresses * Include an effective date
Changing your existing Tax ID to a new Tax ID W-9 is required to process this change	1, 2, 3, 4, 5, 6, 7	* Must include termination date from old Tax ID * Must include practice name and effective date for new Tax ID * Include a copy of updated liability insurance face sheet (for credentialing) (For an individual provider, Area 7 is not required)
* Changes to phone and/or fax numbers	1, 2, 4, 7*	* Document Tax ID and specific address(es) associated with change
* Provider name change	1, 2 (new name), 3 (old name)	* Name must match Ohio State Medical License
* Practice name change	1, 3, 4, 7*	* Must include a W-9 and effective date
* Provider Termination	1, 2, 3	* Must include a termination date
* No longer practicing at a specific location	1, 2, 3, 7*	* Must include a termination date
* Billing/Remit Address Change	1, 3, 5, 7*	* Must include a W-9 and effective date
Informational (Malpractice, 30-day notice, online portal, etc.)	8	
Note: For additional providers, please see Area 7.		

Please submit the completed form to OhioHealth via email:

OH-ProviderChanges@OhioHealth.com or fax: 614-566-0401

Please direct questions regarding this form to: **OH-ProviderChanges@OhioHealth.com**

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

AREA 1: Type of Change (Check all that apply)

- ☐ Adding new location(s) to existing Practice Tax ID
- ☐ Adding new location(s) to a Provider
- ☐ Relocating and changing all address(es)
- ☐ No longer practicing at an address
- ☐ Provider termination
- ☐ Other (please specify): _____
- ☐ Provider name change
- ☐ Adding a new Tax ID (Attach copy of W-9)
- ☐ Changing Tax ID number (Attach copy of W-9)
- ☐ Practice name change (Attach copy of W-9)
- ☐ Change billing/remit address (Attach copy of W-9)

AREA 2: Provider Information

Provider Name: _____
Specialty: _____
Individual NPI: _____
Email Address: _____

AREA 3: Previous Information

Practice Name: _____
DBA: _____
Address Line 1: _____
Address Line 2: _____
Tax ID Number: _____
Group NPI Number: _____
Should this record be terminated for this provider? ☐ Yes ☐ No
If Yes, Termination Date: ____ / ____ / _____

AREA 4: New Information (Attach a separate sheet for additional addresses)

Practice Name: _____
DBA: _____
Effective Date: ____ / ____ / _____
Name on W-9: _____
Legal Name (if different): _____
Address Line 1: _____
Address Line 2: _____
Phone Number: _____
Fax Number: _____
Tax ID Number: _____
Office Contact Person: _____
Group NPI Number: _____
Office Contact Email: _____
Provider's Cell Phone: _____
Answering Service: _____
Is this your Primary Address? ☐ Yes ☐ No
Is this provider accepting new patients at this address? ☐ Yes ☐ No
Should this address be publicized in patient directories? ☐ Yes ☐ No

AREA 5: Billing (Remit) Address

Billing Address: _____
Phone Number: _____
Fax Number: _____
Billing Contact Person: _____
Billing Contact Email: _____

AREA 6: Preferred Mailing Address

Mailing Address: _____
Phone Number: _____
Contact Person: _____
Email Address: _____

AREA 7: Additional Providers Affected by This Change

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

(Attach additional sheet if necessary)

AREA 8: Informational

Current malpractice coverage is required for all providers being added to a new group.
Include a copy of current malpractice face sheet with this form.

We must have a 30-day notice for all changes.
If the effective date is not 30 days in advance, we are advised to future date the change to 30 days out from when we receive it.

Changes can also be made at our online portal located:
https://clinicianportal.ohiohealth.com