MultiCare Connected Care™

www.multicareconnectedcare.com

Provider Demographic Address Change / Term Form

This form must be signed and include a contact's name and phone number before it can be submitted for update. Please return the form to MultiCare Connected Care by email: **MHSProviderEnrollment@multicare.org**

Does this request affect one or more of the following? (*Check all impacted by updated demographics.*)

☐ **Practitioner** ☐ **Group** ☐ **Facility/Ancillary** (*Credentialing may be required for new service location*)

☐ **All practitioners in the Group/Facility** (*Attach a list of all participating practitioners in group*)

What type of change is requested?

☐ **Add** a New Location ☐ **Remove** an Old Location ☐ **Term** *Provider has left group*

EFFECTIVE DATE OF CHANGE or TERM _____

Provider Name: _____ **NPI** (Practitioner*): _____

Tax ID: _____ **NPI** (Group/Facility): _____

* *If more than one practitioner needs to be updated, please attach a separate sheet and list name(s)/NPI.*

Primary Address (*If additional locations, list on separate sheet*)**:**

New Address:

_____

City, State, Zip Code:

_____

Phone: _____ **Email:** _____

Old Address:

_____

City, State, Zip Code:

_____

Phone: _____ **Email:** _____

Authorized provider/Representative Signature: _____

Print Name: _____ Email: _____