Optum

Physician/provider change form

Please use this form for demographic changes or to update your NPI information. Please make sure that all the information is complete as we cannot process incomplete forms. Please email your completed form to **pdmops@optum.com** or fax it to **1-855-202-4313**.

Section I group demographics

Practice/organization name:_____ Current Tax ID (TIN):_____

National Provider Identifier (NPI): _____ Date issued: ____/ ____/____

Basis for NPI (applies to organizations only, select only 1 per NPI):

□ Provider Name □ Tax ID only (entity whose name is in the W-9 form) □ License Number

□ NUCC Taxonomy Code □ Place of service address □ Department

□ Other (please explain) _____

□ Please check here if you have multiple NPIs representing your practice or organization.

□ Name of individual completing this form:_____

Telephone: _____ E-mail: _____

Section II practice/organization information changes (check all that apply)

□ The new tax ID number is: _____ Effective: _____ (please attach a copy of the W-9)

□ We have moved. Our new address is effective: _____

This new address is a:

□ Practice address □ Billing address □ Both practice & billing address

□ Correspondence address

Should this new address be in the directory? ■ Yes □ No

New:	Old:
Telephone:	Telephone:
Fax:	Fax:
E-mail:	E-mail:

□ We have changed our practice name to: _____ Effective: _____

□ Change pertains to all physicians/health care providers under the Tax ID (TIN): _____

□ Specify physicians/health care providers affected by the change:

Section II continued

□ These physicians/health care providers have left our practice.
Name: _____ License: _____
Practice address: _____
Specialty: _____ Individual NPI: _____ Date of termination: _____
Please provide
reason for leaving: _____

Name: _____ License: _____
Practice address: _____
Specialty: _____ Individual NPI: _____ Date of termination: _____
Please provide
reason for leaving: _____

□ These physicians/health care providers have joined our practice (please attach a copy of the W-9).

Name: _____ License: _____ E-mail _____
Practice address: _____
Specialty: _____ Individual NPI: _____ Date of addition: _____

Name: _____ License: _____ E-mail _____
Practice address: _____
Specialty: _____ Individual NPI: _____ CAQH: _____
Date of addition: _____

□ Check this box if you do not have a private office and only see patients at the hospital

Signature of participating
physician/health care provider: _____ Date: _____

Optum

optum.com