



## PROVIDER UPDATE/CHANGE FORM

**Thank you for your continued participation with PPNI. It has come to our attention that we may have incomplete information on your practice due to a changes in location, services offered, telephone numbers, etc. Please complete the Update/Change Form in it's entirely so that we may continue to refer patients to your practice through customer care referral and directory services. Fax your return to (713) 414-4953 Attn: Provider Relations and we will process your updates immediately. Should you require additional assistance please contact the Provider Relations Department at (866) 776-4872.**

Physician Name (Last, M.I., First)		Degree	Tax Identification Number(s)		
(1) Primary Practice/Clinic Name			Specialty	County	
(1) Primary Practice Address (include suite #)			City	State	Zip
Phone	Facsimile		Office Hours		
(2) Practice/Clinic Name			Tax Identification Number(s)		
(2) Practice Address (include suite #)			City	State	Zip
Phone	Facsimile		Office Hours	County	
State Licensed	State License #	ECFMG # (if applicable)	Social Security #	Languages Spoken	
DEA Number	DPS Number		NPI #	Accepts New Patients? Y or N	
Malpractice Insurance Carrier		Limits of Liability		Policy Number	
Provider Billing Address			City	State	Zip
Provider Contact Person		Phone Number		Email Address	

**The provider attests that all information contained in this application is true and accurate. The provider agrees that if changes occur to the aforementioned, that he/she will notify PPNI of such changes within five (5) business days. I have submitted all state/federal licensure/certifications and proof of liability insurance.**

\_\_\_\_\_  
Signature of Provider/Authorized Signatory

\_\_\_\_\_  
Date

***PPNI Use Only***

PPNI Representative	Process Date	PID#
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