1199SEIU Benefit Funds

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Provider Demographic Information Change Request Form

Please type or print legibly to avoid processing delays or complete online.

☐ **Participating provider** ☐ **Non-participating provider**

Current Provider Information

PROVIDER NAME _____ EMAIL ADDRESS(ES) (GROUP OR INDIVIDUAL) _____

SPECIALTY _____ AREA OF INTEREST _____ NPI _____ TAX ID _____

Board certified: ☐ Yes ☐ No

Does the office meet ADA accessibility requirements? ☐ Yes ☐ No

Provider Change Information

This change affects:

☐ Group practice ☐ Individual provider ☐ Institution/Facility Date change will take effect: _____
DATE (MM/DD/YYYY)

Type of Change (Please check all that apply)

☐ Add TIN
☐ Deactivate TIN
☐ Change TIN
☐ Add billing address
☐ Add provider languages spoken: _____
☐ Add Email Yes☐ No☐ _____
☐ Change Email Yes☐ No☐ _____
☐ Add: Staff language spoken _____
☐ Change billing address
☐ Add service address
☐ Delete service address
☐ Change service address
☐ Change name (group or physician): _____
☐ Change or add hospital affiliation: _____
☐ Add specialty: _____
☐ Other: _____
☐ Delete provider language: _____
☐ Accepting new patients? Yes☐ No☐
☐ Add: Office Hours _____
☐ Delete staff language

New Demographic Information

New Service Information
(If more than one location, attach an additional form for each location)

Primary service location? ☐ Yes ☐ No

INDIVIDUAL NAME _____

GROUP NAME/GROUP NPI _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____

FAX _____ TAX ID _____

New Billing Information
(Form W-9 must be submitted with all tax ID updates)

Name: **(As shown on your income tax return)** _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____

FAX _____

TAX ID _____ NPI _____

Old Demographic Information

Old Service Information (If more than one location, attach an additional form for each location)

INDIVIDUAL NAME

GROUP NAME/GROUP NPI

ADDRESS

CITY STATE ZIP CODE

TELEPHONE

FAX TAX ID

Old Billing Information

Name: (As shown on your income tax return)

ADDRESS

CITY STATE ZIP CODE

TELEPHONE

FAX

TAX ID NPI

PRINT NAME AND TITLE OF AUTHORIZED SIGNATURE

X AUTHORIZED SIGNATURE DATE (MM/DD/YYYY) TITLE

EMAIL ADDRESS TELEPHONE FAX

Please fax or email completed form with additional documentation to:

Fax: (646) 473-7229 | Email: Providers@1199Funds.org

Please allow 45 days to process your request. Tax ID updates cannot be processed without a properly completed Form W-9.

INTERNAL USE ONLY

Contract Type

☐ Par professional: _____

☐ Non-par professional: _____

☐ Special contract: _____

☐ MCHCS: _____

☐ Par facility: _____

☐ Non-par facility: _____

Effective date of new contract: _____

Requester initial: _____