Provider Demographic Change Form

CURRENT DEMOGRAPHIC INFORMATION

TODAY'S DATE:		**EFFECTIVE DATE:**	
LEGAL PROVIDER NAME:			
DBA (if applicable):			
Address :	**City:**	**State:**	**Zip Code:**
Phone:		**Fax:**	
Email:			
TAX ID#:	**NPI (s):**	**Email:**	

Demographic Change:	☐ Additional Tax ID	☐ Update Tax ID	☐ Update Office Hours	☐ Additional Location	☐ County (check all that apply)
	☐ Additional NPI	☐ Update NPI	☐ Name/Provider	☐ Address Change	☐ Contact Change
	___**OTHER (PLEASE EXPLAIN)**				

NEW DEMOGRAPHIC INFORMATION

LEGAL PROVIDER NAME:			
DBA (if applicable):			
Address :	**City:**	**State:**	**Zip Code:**
Phone:		**Fax:**	
NPI:	**Tax ID:**	**Email:**	

W-9 Forms are required for the following: *change of address, change of legal name, additional locations.*
Credentialing is required for the following: *New provider or change of Tax ID / NPI*
*https://icirclecarecny.org/ProvidersPartners/ProviderForms/tabid/246/Default.aspx***

Current Tax ID#: _____ ☐ Keep Current Tax ID ☐ Terminate from current Tax ID	**Reason for New Tax ID#:** _____ ☐ Joining exiting TIN/Practice ☐ Change in ownership ☐ New Name for existing Tax ID ☐ Other ☐ New Business – Please complete Credentialing Application
Current NPI#: _____ ☐ Keep Current NPI ☐ Terminate from current NPI	**Reason for New NPI#:** _____ ☐ Joining exiting Practice ☐ Change in ownership ☐ New Name for existing NPI ☐ Other ☐ New Business – Please complete Credentialing Application

☐ **Old Address** ☐ **New Address**	○ **Primary Office**	○ **Additional Office**	○ **Billing / Remittance**				
Address 1:			**City:**	**State:**	**Zip Code:**		
Office Phone:			**Office Fax:**				
Office Hours	Mon____-____	Tues____-____	Wed____-____	Thu____-____	Fri____-____	Sat ____-____	Sun____-____
☐ **Old Address** ☐ **New Address**	○ **Primary Office**	○ **Additional Office**	○ **Billing / Remittance**				
Address 2:			**City:**	**State:**	**Zip Code:**		
Office Phone:			**Office Fax:**				
Office Hours	Mon____-____	Tues____-____	Wed____-____	Thu____-____	Fri____-____	Sat ____-____	Sun____-____
☐ **Old Address** ☐ **New Address**	○ **Primary Office**	○ **Additional Office**	○ **Billing / Remittance**				
Address 3:			**City:**	**State:**	**Zip Code:**		
Office Phone:			**Office Fax:**				
Office Hours	Mon____-____	Tues____-____	Wed____-____	Thu____-____	Fri____-____	Sat ____-____	Sun____-____

ORGANIZATIONAL CONTACT CHANGES:			
Inquiry Type	**Name**	**Phone**	**Email**
Billing			
Contracting			
Credentialing			
Customer Service			
General Questions			
Other			

Service Authorization Contact Name:	**Preferred Method to receive Service Authorizations:**
_____ Phone: _____	Fax ☐ or Email ☐ Please List Fax or Email: _____

PLEASE CHECK THE ALL COUNTIES THAT YOU ARE LICENSED TO PROVIDE SERVICE IN:																			
Allegany	☐	Chemung	☐	Genesee	☐	Niagara	☐	Oswego	☐	Tioga	☐
Broome	☐	Chenango	☐	Herkimer	☐	Oneida	☐	Otsego	☐	Tompkins	☐
Cattaraugus	☐	Cortland	☐	Livingston	☐	Onondaga	☐	Schuyler	☐	Wayne	☐
Cayuga	☐	Delaware	☐	Madison	☐	Ontario	☐	Seneca	☐	Wyoming	☐
Chautauqua	☐	Erie	☐	Monroe	☐	Orleans	☐	Steuben	☐	Yates	☐

☐ **All Counties**	
Completed By:	
Title:	**Date:**

Please fax, email or mail completed form to iCircle **With a copy of your W9**
Fax: 888-519-2816 / Email: ProviderNetwork@icirclecny.org

Mail: iCircle Care
Attn: Provider Relations
860 Hard Rd. Webster, NY 14580

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