



## Guide to Demographic Changes

This form and the associated documentation are required to notify iCircle Services of the Finger Lakes of any changes to your group practice or facility/MLTC ancillary provider. This form is also available at: <https://icirclecny.org/> (see For Providers section for all forms). If making changes to a group practice that affects licensed individual practitioners please include an updated roster. You may use the roster template also available at <https://icirclecny.org/>.

Please contact [ProviderRelations@icirclecny.org](mailto:ProviderRelations@icirclecny.org) should you need any further assistance.

### Instructions for form completion:

- Please complete Section A for all information changes.
- When a W9 is required please fill out the W9 with billing address, not physical address. Only one billing address per Tax ID is allowed.
- For Licensed Provider types please see additional \* requirements
- If reporting a termination a termination letter is required on company letterhead and must include the following: Legal name, Tax ID, Billing NPI, Address of all affected locations, effective date and reason for termination with sufficient notice as outlined in your specific contractual language.
- Proceed to fill out additional sections that are applicable to your change request:

Section B	Complete if changing a Tax ID	Submit W9. *Licensed providers must also submit NYS DOH approval of change in the form of a letter or updated OPCERT. Requires Contracting and Credentialing follow up
Section C	Complete if changing Billing NPI	Requires Credentialing and Contracting follow up
Section D	Complete if changing the legal or DBA name	Submit W9. *Licensed providers must also submit NYS DOH approval of change in the form of a letter or updated OPCERT. Requires Contracting follow up.
Section E	Complete if reporting an address change. Complete all that apply to the address change.	Billing address changes require a new W9 with billing address on W9 form. *Licensed providers must also submit NYS DOH approval of change in the form of a letter or updated OPCERT.
Section F	Complete if reporting a Phone/Fax or Email change not associated with an address change	
Section G	Complete if reporting a change in office hours for Provider Directory	
Section H	Complete if reporting a change to office contact persons	
Section I	Complete if reporting changes to Counties being served	*Licensed providers must also submit NYS DOH approval of additional counties in the form of a letter or updated OPCERT.



## Provider Demographic Change Form

SECTION A * ALL FIELDS IN THIS SECTION ARE REQUIRED					
TODAY'S DATE:			EFFECTIVE DATE of CHANGE:		
PROVIDER LEGAL ENTITY NAME:					
DBA ( if applicable):					
TAX ID#:		NPI (s) include all affected by requested change:			
<b>TYPE OF CHANGE: Check all that apply</b>	<input type="checkbox"/> Add	<input type="checkbox"/> Update	<input type="checkbox"/> Correct	<input type="checkbox"/> Close	<input type="checkbox"/> Terminate (see additional section below)
<b>CHANGE REQUESTED: Check all that apply</b>	<input type="checkbox"/> Name of Provider	<input type="checkbox"/> NPI	<input type="checkbox"/> Tax ID**	<input type="checkbox"/> Telephone/Fax/Email	<input type="checkbox"/> Contact Change
	<input type="checkbox"/> Counties Served	<input type="checkbox"/> Office hours	<input type="checkbox"/> Ownership change (Submit new Disclosure of Ownership form available at icirclecny.org)		
<b>Type of Address Change: Check all that apply</b>	<input type="checkbox"/> Primary Office <input type="checkbox"/> Additional Office <input type="checkbox"/> Billing Address				
<b>IF your change includes a termination complete this section.</b>	<input type="checkbox"/> Termination    Effective Date: _____    Reason for Termination: _____ _____ _____				
	<input type="checkbox"/> OTHER (PLEASE EXPLAIN) _____ _____				
<b>Section B: CHANGE TAX ID</b>	<b>Current Tax ID#:</b> _____ <input type="checkbox"/> Keep current Tax ID (adding additional Tax ID) <input type="checkbox"/> Terminate current Tax ID (replacing with new Tax ID)		<b>New Tax ID:</b> _____ <b>Reason for New/Additional Tax ID#:</b> <input type="checkbox"/> Joining exiting TIN/Practice <input type="checkbox"/> Change in ownership <input type="checkbox"/> New Name for existing Tax ID <input type="checkbox"/> New Business – Please complete Credentialing Application <input type="checkbox"/> Other: _____		
<b>Section C: CHANGE NPI</b>	<b>Current NPI#:</b> _____ <input type="checkbox"/> Keep current NPI (adding additional NPI) <input type="checkbox"/> Terminate current NPI (replacing with new NPI)		<b>New NPI:</b> _____ <b>New Medicaid:</b> _____ <b>Reason for New/Additional NPI#:</b> <input type="checkbox"/> Joining existing TIN/Practice <input type="checkbox"/> Change in ownership <input type="checkbox"/> New Name for existing Tax ID <input type="checkbox"/> New Business – Please complete Credentialing Application <input type="checkbox"/> Other: _____		
<b>Section D: Group Name Change</b>	<b>Previous Legal Name:</b>  <b>Previous DBA Name:</b>		<b>New Legal Name:</b>  <b>New DBA Name:</b>		

<b>Section E: CHANGE OF ADDRESS</b>  Please use additional sheets when needed for multiple addresses.  *Please note: A physical address must be a street level address. PO box is acceptable only as a billing address.	<b>Old Address</b>		<input type="radio"/> Primary Office <input type="radio"/> Additional Office <input type="radio"/> Billing / Remittance           Is location closing? <input type="radio"/> Y <input type="radio"/> N			
	Address:		City:	State:	Zip Code:	
	Office Phone:		Office Fax:			
	<b>New Address</b>		<input type="radio"/> Primary Office <input type="radio"/> Additional Office <input type="radio"/> Billing / Remittance			
	Address:		City:	State:	Zip Code:	
	Office Phone:		Office Fax:			
	Handicap Accessibility? <input type="radio"/> Y <input type="radio"/> N		Include in Provider Directory? <input type="radio"/> Y <input type="radio"/> N			
	<b>Is your Billing Address different than above?</b> <input type="radio"/> Y <input type="radio"/> N if yes complete this section. Include W9.					
	Billing Address:		City:	State:	Zip Code:	
	Billing Phone:		Billing Fax:			
<b>Section F: CHANGE OF PHONE/FAX/ EMAIL without an address change</b>	<b>Address affected by change</b>		<input type="radio"/> Primary Office <input type="radio"/> Additional Office <input type="radio"/> Billing / Remittance			
	Address:		City:	State:	Zip Code:	
	Old Office Phone: Old Office Fax: Old Email:		New Office Phone: New Office Fax: New Email:			

<b>Section G: Change of Office Hours</b>	Mon	Tues	Wed	Thu	Fri	Sat	Sun
	___ am - ___ pm	___ am - ___ pm	___ am - ___ pm	___ am - ___ pm	___ am - ___ pm	___ am - ___ pm	___ am - ___ pm
	Are hours changing for all locations under this Tax ID? <input type="radio"/> Y <input type="radio"/> N Are hours changing for a specific location? <input type="radio"/> Y <input type="radio"/> N if Yes complete this section:						
Address:		City:	State:	Zip Code:			

**SECTION H: ORGANIZATIONAL CONTACT CHANGES**

Inquiry Type	Name of Contact Person	Phone	Fax	Email
Billing				
Contracting				
Credentialing				
Other				

**SECTION I: PLEASE CHECK THE ALL COUNTIES IN WHICH YOU ARE LICENSED TO PROVIDE SERVICE**

<input type="checkbox"/> Albany	<input type="checkbox"/> Cortland	<input type="checkbox"/> Jefferson	<input type="checkbox"/> Onondaga	<input type="checkbox"/> Saratoga	<input type="checkbox"/> Ulster
<input type="checkbox"/> Allegany	<input type="checkbox"/> Delaware	<input type="checkbox"/> Kings	<input type="checkbox"/> Ontario	<input type="checkbox"/> Schenectady	<input type="checkbox"/> Warren
<input type="checkbox"/> Bronx	<input type="checkbox"/> Dutchess	<input type="checkbox"/> Lewis	<input type="checkbox"/> Orange	<input type="checkbox"/> Schoharie	<input type="checkbox"/> Washington
<input type="checkbox"/> Broome	<input type="checkbox"/> Erie	<input type="checkbox"/> Livingston	<input type="checkbox"/> Orleans	<input type="checkbox"/> Schuyler	<input type="checkbox"/> Wayne
<input type="checkbox"/> Cattaraugus	<input type="checkbox"/> Essex	<input type="checkbox"/> Madison	<input type="checkbox"/> Oswego	<input type="checkbox"/> Seneca	<input type="checkbox"/> Westchester
<input type="checkbox"/> Cayuga	<input type="checkbox"/> Franklin	<input type="checkbox"/> Monroe	<input type="checkbox"/> Otsego	<input type="checkbox"/> St. Lawrence	<input type="checkbox"/> Wyoming
<input type="checkbox"/> Chautauqua	<input type="checkbox"/> Fulton	<input type="checkbox"/> Montgomery	<input type="checkbox"/> Putnam	<input type="checkbox"/> Steuben	<input type="checkbox"/> Yates
<input type="checkbox"/> Chemung	<input type="checkbox"/> Genesee	<input type="checkbox"/> Nassau	<input type="checkbox"/> Queens	<input type="checkbox"/> Suffolk	
<input type="checkbox"/> Chenango	<input type="checkbox"/> Greene	<input type="checkbox"/> New York	<input type="checkbox"/> Rensselaer	<input type="checkbox"/> Sullivan	
<input type="checkbox"/> Clinton	<input type="checkbox"/> Hamilton	<input type="checkbox"/> Niagara	<input type="checkbox"/> Richmond	<input type="checkbox"/> Tioga	
<input type="checkbox"/> Columbia	<input type="checkbox"/> Herkimer	<input type="checkbox"/> Oneida	<input type="checkbox"/> Rockland	<input type="checkbox"/> Tompkins	
<input type="checkbox"/> All New York Counties					

<b>Completed By:</b>	
<b>Title:</b>	<b>Date:</b>

Please fYi fb completed form to iCircle **\*with additional supporting documents as required\***  
 Email (preferred): [ProviderRelations@icirclecnny.org](mailto:ProviderRelations@icirclecnny.org) OR Mail: iCircle Care, Attn: Provider Relations, 860 Hard Rd, Webster NY 14580