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://www.icirclecny.org/provider-information/. If making changes to a group practice that affects licensed individual practitioners please include an updated roster. You may use the roster template available through the link above.

Please contact Contracts@icirclecny.org for changes to your Group/Practice Name, Tax ID number, NPI, Ownership or contracted services.

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.**
- 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 with billing address on W9 Form. 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 Requires Contracting follow up
Section E	Complete if reporting an address change. Complete all that apply to the address change.	If you are a licensed provider submit NYS DOH approval of address change in the form of a letter or updated OPCERT. Billing address changes require a new W9 with billing address on W9 form.
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	If you are a licensed provider submit NYS DOH approval of serving county change 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:**			
TYPE OF CHANGE: Check all that apply	☐ Add	☐ Update	☐ Correct	☐ Close	☐ Terminate (see additional section below)
CHANGE REQUESTED: Check all that apply	☐ Name of Provider	☐ NPI	☐ Tax ID**	☐ Telephone/Fax/Email	☐ Contact Change
	☐ Counties Served	☐ Office hours	☐ Ownership change (Submit new Disclosure of Ownership form) https://www.icirclecny.org/provider-information/		
Type of Address Change: Check all that apply	☐ Primary Office	☐ Additional Office	☐ Billing Address		
IF your change includes a termination complete this section.	☐ Termination Effective Date: _____ Reason for Termination: _____				
	☐ OTHER (PLEASE EXPLAIN) _____				

Section B: CHANGE TAX ID	**Current Tax ID#**: _____ ☐ Keep current Tax ID (adding additional Tax ID) ☐ Terminate current Tax ID (replacing with new Tax ID)	**New Tax ID:** _____ **Reason for New/Additional Tax ID#:** ☐ Joining exiting TIN/Practice ☐ Change in ownership ☐ New Name for existing Tax ID ☐ New Business – Please complete Credentialing Application ☐ Other:_____
Section C: CHANGE NPI	**Current NPI#**: _____ ☐ Keep current NPI (adding additional NPI) ☐ Terminate current NPI (replacing with new NPI)	**New NPI:** _____ **New Medicaid:** _____ **Reason for New/Additional NPI#:** ☐ Joining existing TIN/Practice ☐ Change in ownership ☐ New Name for existing Tax ID ☐ New Business – Please complete Credentialing Application ☐ Other: _____
Section D: Group Name Change	**Previous Legal Name:** _____ **Previous DBA Name:** _____	**New Legal Name:** _____ **New DBA Name:** _____

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Section E: CHANGE OF ADDRESS **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.				
	Old Address	○ Primary Office ○ Additional Office ○ Billing / Remittance Is location closing? ○ Y ○ N		
	Address:	**City:**	**State:**	**Zip Code:**
	Office Phone:	**Office Fax:**		
	New Address	○ Primary Office ○ Additional Office ○ Billing / Remittance		
	Address:	**City:**	**State:**	**Zip Code:**
	Office Phone:	**Office Fax:**		
	Handicap Accessibility? ○ Y ○ N	**Include in Provider Directory? ○ Y ○ N**		
	Is your Billing Address different than above? ○ Y ○ N if yes complete this section. Include W9.			
	Billing Address:	**City:**	**State:**	**Zip Code:**
	Billing Phone:	**Billing Fax:**		

Section F: CHANGE OF PHONE/FAX/ EMAIL without an address change				
	Address affected by change	○ Primary Office ○ Additional Office ○ Billing / Remittance		
	Address:	**City:**	**State:**	**Zip Code:**
	Old Office Phone: **Old Office Fax:** **Old Email:**	**New Office Phone:** **New Office Fax:** **New Email:**		

Section G: Change of Office Hours	Mon ___am - ___pm	Tues ___am - ___pm	Wed ___am - ___pm	Thu ___am - ___pm	Fri ___am - ___pm	Sat ___am - ___pm	Sun ___am - ___pm

Are hours changing for all locations under this Tax ID? ○ Y ○ N

Are hours changing for a specific location? ○ Y ○ 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				
Authorizations				
Other				

Service Authorization Contact Changes

Name: _____

Phone: _____ Fax: _____ Email:_____

Preferred Method to receive Service Authorizations: Fax ☐ or Email ☐

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

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

☐ **All New York Counties**

Completed By:	
Title:	**Date:**

Please fax, email or mail completed form to iCircle ***with additional supporting documents as required****

Fax: 888-519-2816 / Email: PFM@icirclecny.org / Mail: iCircle Care, Attn: Provider Network, 860 Hard Rd, Webster NY 14580