



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.**
- **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:			
TYPE OF CHANGE: Check all that apply	<input type="checkbox"/> Add	<input type="checkbox"/> Update	<input type="checkbox"/> Correct	<input type="checkbox"/> Close	<input type="checkbox"/> Terminate (see additional section below)
CHANGE REQUESTED: Check all that apply	<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) https://www.icirclecny.org/provider-information/		
Type of Address Change: Check all that apply	<input type="checkbox"/> Primary Office <input type="checkbox"/> Additional Office <input type="checkbox"/> Billing Address				
IF your change includes a termination complete this section.	<input type="checkbox"/> Termination Effective Date: _____ Reason for Termination: _____ _____				
<input type="checkbox"/> OTHER (PLEASE EXPLAIN) _____ _____					
Section B: CHANGE TAX ID	Current Tax ID#: _____ <input type="checkbox"/> Keep current Tax ID (adding additional Tax ID) <input type="checkbox"/> Terminate current Tax ID (replacing with new Tax ID)		New Tax ID: _____ Reason for New/Additional Tax ID#: <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: _____		
Section C: CHANGE NPI	Current NPI#: _____ <input type="checkbox"/> Keep current NPI (adding additional NPI) <input type="checkbox"/> Terminate current NPI (replacing with new NPI)		New NPI: _____ New Medicaid: _____ Reason for New/Additional NPI#: <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: _____		
Section D: Group Name Change	Previous Legal Name: Previous DBA Name:		New Legal Name: New DBA Name:		

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		<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:			
	New Address		<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			
	Is your Billing Address different than above? <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:			
Section F: CHANGE OF PHONE/FAX/ EMAIL without an address change	Address affected by change		<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:			

Section G: Change of Office Hours	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				
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

<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					

Completed By: _____

Title: _____ Date: _____

Please fYi fb completed form to iCircle **with additional supporting documents as required***
 Email: PFM@icirclecny.org / Mail: iCircle Care, Attn: Provider Network, 860 Hard Rd, Webster NY 14580