

# HNS

## Notification of Physician Name Change

**This form is for use if the only change is to the physician's legal name.**

HNS is responsible for ensuring our database includes accurate information regarding your practice, and for promptly notifying all contracted healthcare plans with any changes regarding your practice.

In order for HNS to make the internal change to your name, and to notify contracted payors of the change, please carefully review the following, and please follow these instructions.

### Instructions:

**1. Please note: Before HNS can make changes to a physician's name in the HNS database, or notify contracted health plans of your new name, you must first do the following:**

**a) Type 1 NPI:**

Notify the government (<https://nppes.cms.hhs.gov/#/>) and update your Type 1 NPI with your new name, *and provide HNS with a printout from the NPI website which shows your new name and your Type 1 NPI.*

**b) Licensing Board:**

Notify your licensing board of your name change, *and provide HNS with a copy of your license which shows your new name (or you may submit an email from your licensing board which makes clear you have notified the Board of your new name).*

2. Please complete both Sections A and B of the form.
3. Please print or type clearly.
4. *Please do not leave any lines blank.* All requested information must be provided.
5. **W-9 Form Required:** You must provide a newly completed W-9 form when submitting this form to HNS.
6. The form must be signed by the provider as his/her attestation of the accuracy of the information on the form.
7. Please email or fax pages 2 and 3 of this form to HNS together with a) a completed W9, b) evidence you have updated your Type 1 NPI with your new name, and c) evidence you have notified your licensing board of your new name.
8. ***Please do NOT notify payors contracted with HNS of this change!***  
HNS will notify all contracted healthcare plans of these changes. (While payors will promptly update their database with these changes, it may take 4-6 weeks for their provider directories to reflect the changes.)

# Notification of Physician Name Change

Date: \_\_\_\_\_ Effective date of change: \_\_\_\_\_

## Section A - Previous Information:

Please provide the following regarding your previous practice information and **complete all blanks.**

Provider Name: \_\_\_\_\_  
(Last) (First) (M)

Legal name of practice: \_\_\_\_\_

DBA: \_\_\_\_\_

Provider Type I NPI: \_\_\_\_\_ Provider Type II NPI: \_\_\_\_\_

TAX ID/EIN: \_\_\_\_\_ Practice Software: \_\_\_\_\_

## **Practice Information**

Practice Physical Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

County: \_\_\_\_\_

Office phone number: \_\_\_\_\_

Office fax number: \_\_\_\_\_

Office contact: \_\_\_\_\_

## **List ALL Providers practicing at this location**

Name of provider	Type 1 NPI	Tax ID (EIN)
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Section B - New Information

Before HNS can make the change to your name or notify contracted healthcare plans of your new name, you must first 1) Update your Type 1 NPI with your new name (website to make this change is <https://nppes.cms.hhs.gov/#/>) and 2) notify your licensing board and confirmed the Board has revised their data to include your new name, and provide evidence to HNS that this has been done.

### **Required Information: When submitting this form to HNS, you must attach the following:**

- Type 1 NPI:** A print out from the NPI Website showing your new name and Type 1 NPI.
- Licensing Board:** A copy of your Chiropractic license showing your new name or an email from the Board confirming you have notified the Board of your name change.
- A completed W9 Form.**

**Additionally, please provide the following information, and please complete all blanks**

Provider Name: \_\_\_\_\_  
(Last) (First) (M)

Legal name of practice: \_\_\_\_\_

DBA: \_\_\_\_\_

Provider Type I NPI: \_\_\_\_\_

Provider Type II NPI: \_\_\_\_\_

TAX ID/EIN: \_\_\_\_\_

Provider's Software: \_\_\_\_\_

**Practice Information**

Practice Physical Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

County: \_\_\_\_\_

Office phone number: \_\_\_\_\_

Office fax number: \_\_\_\_\_

Office contact: \_\_\_\_\_

**Office Hours:**

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of provider

Type 1 NPI

Tax ID (EIN)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature of Provider**

Please email or fax pages **2, 3** of this form to HNS together with the **3 required documents**. HNS Fax:(877) 329-2620.