

HEALTH NETWORK SOLUTIONS, INC.

Provider Change Form

Please complete the following, printing or typing clearly. Fax to HNS at (877) 329-2620

Provider Name: _____ Type I NPI: _____
(Last) (First) (MI)

Effective Date of Change: _____
(today's date or future date)

Completed W9 attached? Yes No
(Changes in Practice Name or Tax ID Number)

Current Information

Providers in Group: _____

Practice Name: _____

Tax ID #: _____

Address: _____

Phone #: _____

Fax #: _____

Type II NPI #: _____

County: _____

New Information

*If no information has changed, please leave that field blank

Providers in Group: _____

Practice Name: _____

Tax ID #: _____

Address: _____

Phone #: _____

Fax #: _____

Type II NPI #: _____

County: _____

Is there a New Billing Address? Yes No

Tax ID changes must choose an option below:

All Revenue from my previous location as well as my new location are payable to me

Revenue from only new location is payable to me

Practice Management Software (Billing Software) of New Location: _____

For HNS Internal Purposes Only:

HNS Provider Rep _____

DB Changed by: _____

QB Changed by: _____

ICP Changed by: _____

Pending Control File

INS Notified by: _____

ICP Rep: _____

Date: _____

Date: _____

Date: _____

EIN Practice Name

Date: _____

BA PA P# F# NPI Add Loc PN DrN EIN

Updated 1/25/08 by CT