

HEALTH NETWORK SOLUTIONS, INC.

Provider Change Form

Today's Date: _____

Please complete the following. **Print or type clearly.** Fax to HNS at (877) 329-2620.

Provider Name: _____ Type 1 NPI: _____
(Last) (First) (MI)

Effective Date of Change: _____ W-9 Attached? Yes No
(MUST be today's date or future date) (W-9 MUST be submitted for Practice Name or EIN changes)

Check all applicable changes to be made:

Billing Address Practice Address Fax# Phone# NPI II Practice Name Provider Name Tax ID/EIN

SECTION A: What is the Current/Old Practice and Billing Information?

List ALL Providers at location: _____
(Include your name) _____

Practice Name: _____ County: _____

Practice Address: _____ * Billing Address: _____

Phone #: _____ Contact Name: _____

Fax #: _____ Contact Phone: _____

Tax ID # (EIN): _____ Software: _____

Type II NPI: _____

SECTION B: What is the New Practice and Billing Information?

(Fill in ONLY the information from Section A that is changing; otherwise, leave blank.)

List ALL Providers at location: _____
(Include your name) _____

Practice Name: _____ County: _____
(MUST match the "Name" or "Business Name" from W-9)

Practice Address: _____ * Billing Address: _____

Phone #: _____ Contact Name: _____

Fax #: _____ Contact Phone: _____

Tax ID # (EIN): _____ Type II NPI: _____

Any Change in software? Yes No If yes, what is the name of the new software? _____

SECTION C: Revenue Information: (Must be completed)

* **Please Note:** If revenue is to be paid to two different places, then two different Tax ID (EIN) numbers are required.
HNS's system is based on Tax ID (EIN) numbers and this determines how monies are paid.

1. For dates of service prior to the effective date of change, send my revenue to?

OLD Billing Address/EIN NEW Billing Address/EIN

2. For dates of service after the effective date of change, send my revenue to?

OLD Billing Address/EIN NEW Billing Address/EIN

HNS Provider Rep: _____ ICP Rep: _____