HealthChoice

IDRS Oklahoma Department of Rehabilitation Services

DOC Department of Corrections Oklahoma

NETWORK PROVIDER CHANGE FORM

Name: _____
(Last) (First) (Middle) (License Type)

NPI Number: _____

Primary Specialty: _____

Secondary Specialty: _____

New Physical Address

Office Name: _____

Office Address: _____

_____
(City) (State) (Zip)

Phone: (____)_____

Fax: (____)_____

Contact Person: _____

Email Address: _____

New Mailing Address

(List any additional physical addresses on a separate sheet)

Office Name: _____

Office Address: _____

_____
(City) (State) (Zip)

Phone: (____)_____

Fax: (____)_____

Contact Person: _____

Email Address: _____

New Billing Address

(List any additional billing addresses on a separate sheet)

Billing Name: _____

Billing Address: _____

_____
(City) (State) (Zip)

Phone: (____)_____

Fax: (____)_____

Contact Person: _____

Email Address: _____

Tax ID Number (TIN)

(Attach a completed W-9 Form)

Tax ID Number: _____

Did this TIN change? Yes ☐ No ☐

If yes, previous TIN: _____

Effective date of this change: _____

Former Physical Address

(Required if changing address)

Office Name: _____

Office Address: _____

_____
(City) (State) (Zip)

Phone: (____)_____

Contact Name (Print): _____

Authorized Signature: _____

Former Billing Address

(Required if changing address)

Billing Name: _____

Billing Address: _____

_____
(City) (State) (Zip)

Phone: (____)_____

Phone: (____)_____

Date: _____

Failure to provide the requested information could result in the delay of payment and/or non-payment of claims

Office Mailing Address, if listed, will be utilized for all legal contractual notices as defined in section 12.2 of the provider contracts and for all credentialing notices/documents. Claims Payment Address, if listed, will be used for all payment related notices/documents.

Return fax numbers: 1-405-717-8977 or 1-405-717-8702
Email addresses: EGID.NetworkManagement@omes.ok.gov

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