AMIDA CARE
ABOVE AND BEYOND FOR YOU

Provider Information Update Form

Section I: Provider Information – *Please complete all fields*: Date of Request: _____

Provider's Full Name: _____ Type: ☐ PCP ☐ HIV PCP ☐ Specialist

Amida Care Provider ID#: _____ Social Security Number/Tax ID: _____

Medicare #: _____ Medicaid #_____

Medical /NYS License #: _____ NPI #: _____

Specialty:_____ Secondary Specialty_____

Office Contact Name:_____ Telephone # ( ) Email Address: _____

Section II: Languages Spoken – *Please check the "Staff" box if the language is spoken only by staff.*

(1.) ☐ Staff	(2.) ☐ Staff	(3.) ☐ Staff

Section III: Service Location – *Please submit a separate form for each additional location.*

☐ Add new location ☐ Relocated ☐ Expire Location ☐ Correction to existing location

Current:			**New:** ☐ Office Location ☐ Hospital Based Location ☐ Other (Independent Diagnostic Center, Supplier, Etc.		
Street Address:			Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Telephone Number ( )	Fax Number ( )		Telephone Number ( )	Fax Number ( )	
Email Address:			Email Address:		

Section IV: Office Hours

Office Hours							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A.M							
P.M							

Section V: Payment/Billing Address

Previous			New		
Provider Name (last, first, middle initial/business name)			Provider Name (last, first, middle initial/business name)		
Street Address:			Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Telephone Number ( )	Fax Number ( )		Telephone Number ( )	Fax Number ( )	
Email Address:			Email Address:		

Section VI: Tax Identification/Employer Identification Number (TIN/EIN) - *A completed W-9 must be attached to this form in order for us to update your Tax ID.*

Previous TIN/EIN	New TIN/EIN	Effective Date of Change

Section VII: Hospital Affiliation Update

Hospital Name:	Hospital NPI	Add/Delete?	Effective Date/ Expiration Date
(1)		Add ☐ Delete ☐	
(2)		Add ☐ Delete ☐	

Additional Comments

_____

_____

_____

Print Name of Provider: _____ **Signature of Provider**: _____

Completed by: ***(Please print)*** _____ **Signature:** _____

Return to: providerservices@amidacareny.org or via fax 646-786-1803