Provider Modification Form

Type of Change: (Please check all that apply):

☐ Add TIN	☐ Change Billing Address	☐ Change Name (Group or Physician)
☐ Deactivate TIN	☐ Add Service Address	☐ Change or Add Hospital Affiliation
☐ Change TIN	☐ Delete Service Address	☐ Change Specialty

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

Provider/Organization Name: _____Type: ☐ PCP ☐ HIV PCP ☐ Specialty___

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.*

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 - : **(W-9 FORM MUST BE SUBMITTED WITH ALL TAX ID UPDATES)**

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:		

Additional Comments

_____

_____

_____

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

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