PARAMOUNT HEALTH CARE
PROVIDER DATA FORM

Please provide all information pertinent to changes you are requesting. Forward the completed form to: Provider Relations Department, Paramount Health Care, P. O. Box 928, Toledo, OH 43697 or fax to: Provider Relations Department 419-887-2021. Any questions: Please call the Provider Relations Department at (419) 887-2855.

Today's Date: _____ Provider ID # _____

Provider/Group Name: _____

Contact Person: _____
(PLEASE PRINT)

Office Address:_____

Phone Number_____

Effective Date of Change: _____

Required New Data:

NPI # _____
(PLEASE ATTACH A LIST OF ALL NPI NUMBERS YOUR PRACTICE USES)

Signature: _____Title: _____
(PLEASE PRINT)

INDICATE TYPE OF CHANGE BEING MADE:

Change of Primary Practice/Business Address	☐	Close To New Patients	☐
Change of Billing Address	☐	Open to New Patients	☐
Change/Addition of Secondary Location	☐	Change in Office Hours	☐
Change in Tax ID# (30 DAY NOTICE REQUIRED)	☐	Termination (90 DAY NOTICE REQUIRED)	☐
Change/Addition to On-Call Arrangements	☐		

IF ANY OF THE CHANGES REQUIRE MORE SPACE THAN LISTED BELOW, ATTACH A LIST OF YOUR CHANGES

New Primary Address: _____

Old Primary Address: _____

New Billing Address: _____

Old Billing Address: _____

New Secondary Address: _____

New Phone Number ( ) _____ Fax: ( )_____

New Tax ID #: _____(ATTACH OR FAX NEW W-9)

New Office Hours: _____

Termination – Effective Date: _____

New On-Call Arrangements: _____

Provider Rep Signature: _____

FOR INTERNAL USE ONLY