Professional/Provider Change Form

TOTAL HEALTH CARE, INC.

Dear Provider,

Please complete the form below to notify Total Health Care of any changes you want to make. Completed forms can be electronically submitted to Providerupdate@THC-Online.com or faxed to (586) 461-2525.

All change requests will be processed within 10 business days of the date we receive the change form.

Please check applicable items below and complete the required information.

☐ Office/Site Address Change

Previous Address, City, Zip Code _____

New Address, City, Zip Code _____

New Phone Number _____

☐ Billing Name Change

Previous Billing Name _____

New Billing Name _____

☐ Billing Address Change

Previous Address, City, Zip Code _____

New Address, City, Zip Code _____

New Phone Number _____

☐ Change in Tax ID – Completed W-9 must be included with Provider Change Form

Previous Tax ID _____

New Tax ID _____

Effective Date _____

Other Information or Changes (Please Specify): _____

_____

_____ _____

Name (Please Print) NPI Number

_____ _____

Authorized Signature Date