

Update Form

Organization/Practice Name: _____

Tax Id Number: _____ Effective Date of Change: _____

Please update the directory listing as specified below. (Check all that apply.)

- Name Change for Organization
New Name: _____
Former Name: _____
- Tax Identification Number (TIN) Change (this may warrant an Amendment to your Agreement)
New TIN: _____ Former TIN: _____
- Address Change to existing service location
New Address: _____
Previous Address: _____
- New Service Location
Address: _____
Phone: _____ Fax: _____
Office Hours (circle if offered at this location): evening weekend
Staff Practicing at this Location: _____
- Closed Service Location (if business closed, check here)
Address: _____
Closing Date: _____
- A current physician will be practicing at additional service locations
Physicians name: _____
Clinic/location address(es): _____

- A physician will be leaving the practice (no longer using the organizations Tax ID #)
Physicians name: _____ Term date: _____

★ If you have a **new** physician practicing at your clinic, this is the wrong form. Please complete a Practitioner Registration Form which can be found on our website.

- Billing Office Address Change
New Address: _____
Previous Address: _____
- Phone/Fax Number Change
New Phone: _____ Former Phone: _____
New Fax: _____ Former Fax: _____
- Contact change for your Organization
Add New Contact
Name: _____ Title: _____
Address: _____
Phone: _____ Fax: _____
Email: _____
Contact type: (check all that apply): Billing Contracting Credentialing
Remove Previous Contact
Name: _____
- Other (please specify): _____

I hereby certify that I have the authority to make change(s) on behalf of the organization listed above.

Signature of Authorized Representative
Please return this completed form to:

Print Name _____

Date _____

Phone number _____



Attn: Provider Relations
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