Provider/Facility Demographic Information Update Form

I am requesting the following change(s) be made. Check appropriate box (es):

☐ **New Group / Practice Name**
☐ **Physical Address**
☐ **Billing Address**
☐ **Facility/Hospital change of ownership**
☐ **Accepting/Not Accepting New Patients**
☐ **New Group NPI**

Effective date of Changes ___________________________

Practice/Facility Name: ____ Tax ID # ______________________________________

Practice/Facility NPI#_____________________________ Practice Medical Group Affiliation: ____

Facility/Hospital Accreditation: ___________________________________ Accreditation Status: _____________ Accreditation Date: ____________

Contact Person ______________________________________ Phone# ______________________________ Fax# ____________________________

Contact Email ____

☐ **Current Physical Address** (attach list if more than one location)
Print in Directory ☐ **Yes** ☐ **No**
New Place of Service:

____

____

Phone ____

Fax ____

Changed / Additional (Circle One)
Old Place of Service:

____

____

Phone ____

Fax ____

Providers associated with this change (if more providers, attach separate page with this detail information):

Provider Name	Specialty	Brd Certification	Brd Eff Date	Brd Exp Date	Languages spoken by Provider	Hosp Affiliation

☐ **Current Billing Address**
New Billing Address:

____

____

Phone ____

Fax ____

Changed / Additional (Circle One)
Old Billing Address:

____

____

Phone ____

Fax ____

☐ **Group / Practice Name**

New Name ____ Facility/Hospital Change of Ownership: ______________________________

☐ **We are no longer accepting new patients.**

☐ **We are accepting new patients.**

☐ **Group NPI:** ____

X ____ ____
Signature **Date**

You may Mail, Fax or Email Complete Form to: Fresenius Health Partners: Provider Database
7100 Commerce Way, Suite 285, Brentwood, TN 37207 or Fax: 615-782-7876 or email Provider.Database@whptn.com