

CENTRAL GEORGIA HEALTH NETWORK

(DEMOGRAPHIC FORM) Revised 8/4/2015

EFFECTIVE AS OF / /

Type of Notification (**Please check all that apply**):

- Provider Joining Practice Provider Leaving Practice Add Provider Address Term Provider Address
 Opening New Office **Closing Office** New Billing Address Update Contact Information
 Other (Please Specify):

Provider: (for changes to provider only)

| | | | | | |
|-------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| Last Name | First Name | Middle Name | Suffix | Degree | Provider NPI # |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Providers Email Address | | Specialty | | | |
| <input type="text"/> | | <input type="text"/> | | | |

Group Name:

Closing Office Address:

Terminate TIN

Office Address/Contact Information:

| | | | | |
|------------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Street Address/Suite # | City | State | Zip | County |

Medicare #

Medicaid #

() -
Office Phone #

() -
Office fax #

Office Web-Site

Office Managers Name

Email Address **Tax ID #**

Accepting New Patients:

Yes No

Handicap Access:

Yes No

Print in Directory:

Yes No

Hospital/Office-based location:

Hospital Office

Billing Address:

| | | | | |
|------------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Street Address/Suite # | City | State | Zip | County |

() -
Billing Phone #

() -
Billing fax #

Billing Managers Name

Email Address

Correspondence Address:

| | | | | |
|------------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Street Address/Suite # | City | State | Zip | County |

() -
Correspondence Phone #

() -
Correspondence fax #

Correspondence Contact Name

Correspondence Contact Email Address

Change Authorization:

Name: Title:

Date:

Comment:

If applicable, please complete as many as needed for additional office locations

Additional Office Correspondence Address:

| | | | | |
|------------------------|------|-----------|--------|--|
| | | | | |
| Street Address/Suite # | City | State Zip | County | |

Medicaid #

() -
Office Phone #

() -
Office fax #

Office Web-Site

Office Managers Name

Email Address

Tax ID #

Print in Directory: Yes No

Additional Office Correspondence Address:

| | | | | |
|------------------------|------|-----------|--------|--|
| | | | | |
| Street Address/Suite # | City | State Zip | County | |

Medicaid #

() -
Office Phone #

() -
Office fax #

Office Web-Site

Office Managers Name

Email Address

Tax ID #

Print in Directory: Yes No

Additional Office Correspondence Address:

| | | | | |
|------------------------|------|-----------|--------|--|
| | | | | |
| Street Address/Suite # | City | State Zip | County | |

Medicaid #

() -
Office Phone #

() -
Office fax #

Office Web-Site

Office Managers Name

Email Address

Tax ID #

Print in Directory: Yes No