

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:

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:

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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:

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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:

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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