PROVIDER UPDATE FORM

Provider Name: ____________________

Provider NPI: ____________________

Group Name: ____________________

Group NPI: ____________________

Provider Specialty: ____________________

Language(s) : ____________________

Practice Location

A. Select one of the following:

☐ Add Location ☐ Terminate Location ☐ Panel Close To New Patients

B. Select one of the following:

☐ Primary Address ☐ Additional Address ☐ Wheelchair Access

Practice Name: ____________________

Street: ____________________

City, State & Zip: ____________________

Hospital Affiliation: ____________________

County: ____________________

Phone Number: ____________________

Fax Number: ____________________

Office Hours: ____________________

Email Address: ____________________

Office Manager: ____________________

Payee/Billing Information

Payable To: ____________________

Street: ____________________

City, State & Zip: ____________________

Tax ID#: ____________________

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Payee/Billing Information

Payable To: ____________________

Street: ____________________

City, State & Zip: ____________________

Tax ID#: ____________________

PLEASE NOTE: SUBMIT ONE PROVIDER UPDATE FORM PER TAX ID NUMBER.

Signature: ____________________

Print Name: ____________________

Date: ____________________

“Easy Choice Health Plan of New York” is a marketing name for Atlantis Health Plan, Inc.

Certain changes to your provider file require supporting documentation and /or credentials:
Hospital Affiliations-Hospital Privelege Letter.
Adding a Specialty-Submit a Copy of Board Certification; subject to credentialing.