Atlantis Provider Profile Update

Check Applicable:

- ☐ **Terminate Contract**
- ☐ **Add/Change Location**
- ☐ **Name Change**
- ☐ **Tax ID or NPI Update**
- ☐ **No longer with Group**
- ☐ **Add/Delete Hospital Affiliation**
- ☐ **Add/Delete Specialty**
- ☐ **Panel Closed**
- ☐ **Updated Telephone/Email/Fax**

Provider First Name: _____
Provider Last Name: _____
Provider ID#: _____
Group Name (if applicable): _____

Select ADD or DELETE:

ADD / DELETE:

Address: _____ Phone #: _____
_____ Fax #: _____
_____ Email: _____
Office Mgr.: _____ Tax ID #: _____
NPI#: _____

ADD / DELETE:

Address: _____ Phone #: _____
_____ Fax #: _____
_____ Email: _____
Office Mgr.: _____ Tax ID #: _____
NPI#: _____

ADD / DELETE:

Specialty: _____

ADD / DELETE:

Hospital Affiliation: _____

ADD / DELETE:

Tax ID#: _____ NPI #: _____

Please send this form to:

Atlantis Health Plan
Attn: Credentialing Department
45 Broadway, Ste. 300
New York, NY 10006
Fax: 646-929-9216

PROVIDER OR OFFICE MANAGER MUST SIGN/DATE FOR CHANGES TO BE IMPLEMENTED

Signature: _____
Print Name: _____
Date: _____

Certain changes to your provider profile require supporting documentation and/ or credentials:
New Location: If a new location will be used for billing, a completed W-9 must be submitted with this form.
Hospital Affiliations: Hospital Privilege Letter.
Adding a Specialty: Submit Copy of Board Certification.

ATLANTIS HEALTH PLAN
By Doctors. For New Yorkers.