Clear Form

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BEHAVIORAL HEALTH SYSTEMS

PROVIDER UPDATE FORM

Please use this form to let us know of any practice changes. You may complete this form on-line, print, then fax or mail to the address above. You may also save this form on your computer and email a completed change to providerrelations@behavioralhealthsystems.com.

Provider Name: Date of Birth: / /

Group / Practice Name:

Social Security Number: - - Tax ID#: -

National Provider Identifier (NPI), if obtained:

Current Primary Office Location:

Telephone: Fax:

Should mail / claims payment be sent to primary address? ☐ Yes ☐ No

If no, address for mail / claims payments:

Do you have the capability to submit claims electronically? ☐ Yes ☐ No

Which clearinghouse or vendor do you currently use?

Additional office location(s):

Telephone: Fax:

Has your office address changed within the last two (2) years: ☐ Yes ☐ No

Previous Office Location:

Previous Tax ID#: - Effective Date of Change:

Change is ☐ Additional location

☐ Replacement location If yes, ☐ replaces all previous locations.

☐ replaces only locations shown.

Hospitals where you have privileges:

This form was completed by: _____

Note: If you are providing new or updated information, please also submit a completed W-9, along with current copies of your state license, and liability insurance.