PO Box 360, South Bend, IN 46624, Telephone 866-925-5730, Fax 574-271-5980
ProviderInfo@NewAvenuesOnline.com

Section A. GENERAL INFORMATION

Current Group/Practice Name			
Practice Tax ID Number			
Provider First Name	MI	Last Name	Licensure

Section B. REASON FOR SUBMITTING FORM

❑Practice Name Change ❑Practice Address Change ❑Practice Phone Change ❑Practice Fax Change ❑Practice Email Change ❑Delete Practice Location	❑Billing Name Change ❑Billing Address Change ❑Billing Phone Change ❑Billing Fax Change ❑Billing Email Change ❑Delete Billing Location	❑Adding Location ❑Practice Hours Change ❑Additional Certification ❑Tax ID Change ❑ Deleting Provider from Group	**Effective Date: Add, Delete or Change** Brief description of change:____ ____

Section C. Previous or old Practice Address Required / Complete billing address if different from practice address.

Section C. Previous or old Practice Address Required	Complete billing address if different from practice address.
Previous Practice Name	Previous Billing Tax ID
Previous Practice Address	Previous Billing Address
City State Zip County	City State Zip County
Phone Number Fax After Hours/ER Number	Phone Number Fax After Hours/ER Number
❑ On Call ❑ Answering Svc ❑ Cell	❑ On Call ❑ Answering Svc ❑ Cell
Email Address:	Email Address:

Section D. New Practice Address

New Practice Name

New Practice Address

City State Zip County

Phone Number Fax After Hours/ER Number

Email Address: ❑ On Call ❑ Answering Svc ❑ Cell

New Practice Tax ID

New Billing Address

City State Zip County

Phone Number Fax After Hours/ER Number

Email Address: ❑ On Call ❑ Answering Svc ❑ Cell

Mon.	Tue.	Wed.	Thur.	Fri.	Sat.	Sun.

Section E. Additional Office Locations

Second Practice Name

Second Practice Address

City State Zip County

Phone Number Fax After Hours/ER Number

Email Address: ❑ On Call ❑ Answering Svc ❑ Cell

Second Practice Tax ID#

Second Billing Address

City State Zip County

Phone Number Fax After Hours/ER Number

Email Address: ❑ On Call ❑ Answering Svc ❑ Cell

Practice Hours

Mon.	Tue.	Wed.	Thur.	Fri.	Sat.	Sun.

Section G. Signature

Provider Signature Date

Please fax completed form together with a current copy of your malpractice insurance face sheet $1,000,000/$3,000,000minimum requirement and W-9 Tax Form, for each practice site, if using multiple Tax ID numbers.

Please fax this completed form to: 574-271-5980

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