ARK-LA-TEX
HEALTH NETWORK

Provider Update/Change of Data Request Form

Please use this form to indicate changes/adds in your demographic information. If this change request applies to multiple providers within your group, please complete the second page of the form with each providers information. Please complete only the applicable sections that are changing/adding. If you are adding a new TIN to this provider's record, a fee of $100 is required.

Provider Name:________________________________**Degree:**_________**Provider NPI #:** ____________________________

Doing Business As:____**Group NPI #:**_________________________

Change Effective Date:_____________________________________**PCP or Specialist:**_____________________________

Primary Contact Person:____**Title:**_________________________

Email Address:____**Phone Number:**________________________________

Description of Change/Add:____

____

PRACTICE LOCATION INFORMATION - Must have a street address - PO Boxes are not acceptable.

Is this a location add or change? Add ☐ Change ☐
Please specify which you are changing or adding? Primary Location ☐ Secondary Location ☐

Practice Location Address:____

Practice Location City, State, Zip:____

Office Phone Number:_________________________________Office Fax Number:_____________________________________

MAILING LOCATION INFORMATION – For correspondence, notifications, newsletters, updates, credentialing information, etc.

Correspondence Address:____

Correspondence City, State, Zip:____

Phone Number:____________________________________ Fax Number:____

BILLING INFORMATION

Billing Company Name:____Billing TIN/EIN:_______________________________

Billing Address:____

Billing City, State, Zip:____

Billing Phone Number:___________________________________Billing Fax Number:_____________________________________

PAYMENT INFORMATION

Payment Name:____

Payment Address:____

Payment City, State, Zip:____

Payment Phone Number:____________________________ Payment Fax Number:____

Signature:____**Date:**_____________________________
(group/facility administrator, designated contact, or provider)

Print Name:____**Title:**____

Please provide complete information – Your request will be processed for all of your active payors. Changes will be requested to be effective as of the date indicated above. If a change effective date is not provided, the date of signature will be considered the effective date. Complete all information as applicable. Incomplete submission cannot be processed and will be returned for corrections. For questions, contact ALT PHO @ 903-614-5382 or email ALTMC@christushealth.org

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ADDITIONAL PROVDIER PAGE

Provider Name and Title:________________________________ **Provider NPI #:**____________________

Provider Name and Title:________________________________ **Provider NPI #:**____________________

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