Physician and provider demographic change submission form

Please use this form for demographic changes or to update your NPI information.

Please ensure that ALL pertinent information is completed as we will be unable to process incomplete forms. Complete all information pertaining to your practice. Fields with an asterisk (*) are required.

Please reference the Table on page 3 for the email address for UnitedHealthcare and its affiliates/alliances, including email address and applicable states. Please email your completed form to the appropriate email address.

Section I Group demographics

Practice/Organization Name | Current Tax ID (TIN)

National Provider Identifier | Date issued / /

Medicaid ID number

Please refer to Section III (page 2) of this fax form for taxonomy code definitions

*Please list your NUCC Taxonomy Code(s) 1) 2) 3) 4) 5)

Basis for NPI (applies to organizations only, select only 1 per NPI):
☐ Provider Name ☐ Tax ID only (entity whose name is in the W-9 form) ☐ License Number ☐ NUCC Taxonomy Code
☐ Place of Service Address ☐ Department ☐ Other (please explain)

☐ Please check here if you have multiple NPIs representing your Practice or Organization.
Refer to **Section III** (page 2) of this fax form.

Name of individual completing this form

Telephone ( ) | Email

Section II Practice/Organization information changes

☐ The new tax ID number is: | *Effective | (please attach a copy of the W-9)

☐ We have moved. Our new address is effective

This new address is a: ☐ Practice Address ☐ Billing Address ☐ Both Practice & Billing Address ☐ Correspondence Address

Should this new address print in the directory? ☐ Yes ☐ No

New	Old
Telephone	Telephone
Fax	Fax
Email	Email

We have changed our practice name to: | *Effective Date:

☐ These physicians/health care providers have left our practice (please provide the effective date and reason for leaving):

☐ These physicians/health care providers have joined our practice effective_____. (please attach a copy of the W-9)

Section II (*continued)*

☐

☐ Specify physicians/health care providers affected by the change:

☐ We are closing our practice to new patients effective

☐ We are reopening our practice to new patients effective

☐ Check this box if you do not have a private office and only see patients at the hospital

Signature of Participating Physician/Health Care Provider: **Date**

Section III National Provider Identification – Requested information

We would like to capture the "basis" or reason for each NPI, if the organization has more than one NPI or has sub-parts that have NPIs. Please use the grid below as a reference when filling in the "Basis for NPI" and Level Information columns in the NPI Collection Grid below (page 3).

If the Basis for your NPI is:	Then supply this information in the Level Information column	Instructional information
C = Entity whose name is on the W-9	Tax ID and Name Filed on W-9	If the organization or sub-part was enumerated strictly on the basis of the name associated with the Tax ID on the W-9 form, then use a "C" in the "Basis for NPI" column. (You will need to indicate whether the Tax ID is a Social Security number or if it is an employer identification number.) Place the Tax ID in the "Level Information"
D = Department	Department Name	If the organization or sub-part was enumerated on the basis of a particular department, provide the Department Name that the NPI was based on, and designate this with a "D" in the "Basis for NPI" column. Insert the Department Name in the "Level Information" column.
L = License	License Number and State or (state code)	If the organization or sub-part was enumerated by License, provide the state or (state code) and License Number that the NPI was based on, and designate this with an "L" in the "Basis for NPI" column. Insert the License Number and state or state code) in the "Level Information" column.
P = Place of Service Address	Place of Service Address (Street, City, State, ZIP +4)	If the organization was enumerated by place of service address, provide the street address that the NPI was based on and designate this with a "P" in the "Basis for NPI" column. Insert the Place of Service address in the "Level Information" column.
T= Tax ID Number and Provider Name	Tax ID and Provider Name, where provider is not the name on the W-9, but bills using this TIN	If the organization or sub-part was enumerated by Tax ID and Provider Name, where the provider is not the name listed on the W-9, but uses this TIN, then designate this with a "T" in the "Basis for NPI" column. Place the Tax ID in the "Level Information" column and indicate whether the Tax ID is a Social Security number or if it is an employer identification number.
X = Taxonomy	NUCC Taxonomy Code	If the organization or sub-part was enumerated by a NUCC Taxonomy code, please provide the Taxonomy Code that the NPI was based on and designate this with an "X" in the "Basis for NPI" column. Place the NUCC Taxonomy Code in the "Level Information" column.
O = Other	Specify details for selecting 'Other'	Provide any other basis for NPI in the "Basis for NPI" column and designate as "O", with a description of the basis for that NPI in the "Level Information" column.
M = Name	Provider Name	This is intended for use by physicians and allied health professionals (people providers). Insert the name in the "Level Information" column.

NPI collection grid

In the grid below please insert your Organization or Sub-Part NPI Number, Name, and Taxonomy Code(s) associated with that NPI. Please indicate the basis for that particular NPI with the appropriate letter from the grid above in the "Basis for NPI" column. Indicate the appropriate "Level Information". If the number of NPIs exceeds this sheet, please use the formatted spreadsheet (NPI Tracking Template) available on UnitedHealthcareOnline.com > Most Visited > National Provider Identifier (NPI) > Multiple NPI Submission Fax Form to list your NPIs.

NPI Number	Organization / Sub-Part Name	Taxonomy Code (Codes associated with each individual NPI)	Basis For NPI	Level Information	NPI Issue Date MM/DD/YYYY

Name of individual completing this form

Telephone ( ) Email

Please email your completed form to the appropriate email address below.

UnitedHealthcare and its affiliates/alliances	E-mail address	States (if applicable)
UnitedHealthcare	hpdemo@uhc.com	AL, AK, AR, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, NE, NH, NM, NV, OH, PA, PR, RI, SC, SD, TN, UNY (Upstate NY), Empire (Markets 99309, 99310, 99318), UT, VA, VI, VT, WI, WV, WY
UnitedHealthcare West	phshpdemo@uhc.com	AZ, CA, CO, OK, OR, TX, WA
UnitedHealthcare/Oxford	ox_hpdemo@uhc.com	CT, NJ, NY (excludes upstate NY and Empire Health Plans)
Harvard Pilgrim Healthcare Medica	lb_hpdemo@uhc.com	
Neighborhood Health Partnership	jdhpdemo@uhc.com	
UnitedHealthcare Plan of the River Valley Inc.	jdhpdemo@uhc.com	