

Maine Network for Health: Change in Practice Form (attach completed W9)

Please allow us 60 days' notice of **name or address change, moving, retiring,** or other changes related to your practice. If the professional is deceased, please contact us immediately by telephone or in writing.

GENERAL INFORMATION: **REQUIRED**			
Provider's Name:		Primary Care Provider: _____	
		Speciality Care Provider: _____	
Group Practice Name:		Type of Speciality:	
		Group/Practice TAX ID#:	
REASON FOR SUBMITTING FORM **REQUIRED**			
Briefly describe the reason for submitting this form:			
REQUIRED EFFECTIVE DATE OF ADD CHANGE TERMINATION _____/_____/_____ Circle ADD, CHANGE, or TERMINATION			
REQUIRED IF CHANGING ADDRESS, INCLUDE OLD ADDRESS HERE			
Practice Name		TAX ID#	
Practice Address		City, ST	Zip
Telephone	Fax	Office Contact	
Billing Address		City, ST	Zip
Billing Telephone	Billing Fax	Billing Contact	
ADDRESS INFORMATION CHANGE - NOTE NEW ADDRESS INFORMATION HERE			
Practice Name		New TAX ID#	
Practice Address		City, ST	Zip
Telephone	Fax	Office Contact	
Billing Address		City, ST	Zip
Billing Telephone	Billing Fax	Billing Contact	
ADDITIONAL OFFICE LOCATION(S)			
Second Practice Name		TAX ID#	
Practice Address		City, ST	Zip
Telephone	Fax	Office Contact	
Billing Address		City, ST	Zip
Billing Telephone	Billing Fax	Billing Contact	
PCP'S ONLY: COVERING PHYSICIAN(S)			
Add or Delete?	Name/Degree	Specialty	Effective date

MISCELLANEOUS PROVIDER INFORMATION

- 1) I am accepting _____ New Patients _____ Current patients & family members _____ Current patients
- 2) I limit the age of patients to: _____ years -- MIN / MAX (circle one)
- 3) New Office Hours: _____
- 4) Name Change: _____
- 5) Specialty Change/Additional Specialty: _____
- 6) I am going on a Leave of Absence from ___/___/___ and will return ___/___/___
The following providers will care for my patients during my leave of absence: _____
- 7) I will be retiring effective ___/___/___ and the following providers will care for my patients: _____

CONTACT INFORMATION

Contact Signature

Contact Name	Telephone	Date
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I, the undersigned professional, request the above change(s). I direct that all payments under my contract(s) with Maine Network for Health for professional services be made to the entity identified as practice name above, and I authorize the release of all financial and practice information to that entity.

Professional's Signature: _____ Date: _____

Contact person for questions regarding the information on this form:

Name: Melinda Wood, Network Support Specialist TEL: (207) 942-2844 FAX: (207) 942-2723

Please mail/fax to: Maine Network for Health, 80 Exchange Street, Suite 603, Bangor, ME 04401