

PROVIDER NOTIFICATION OF CHANGE

To submit this form, download it to your computer, complete and save, and attach it to an **email to:** ProviderRelations@coaccess.com. You may also **fax:** 303-755-2368, or **mail:** Colorado Access, Attn: Provider Relations, PO Box 17580, Denver, CO 80217-0580.

TAX IDENTIFICATION INFORMATION

Are you changing the Tax Identification Number (TIN) that is on file with us? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please provide former TIN (the TIN Colorado Access has on file):</i>
<i>If yes, please provide new/current TIN:</i>
Effective date:

NPI NUMBER INFORMATION

Are you changing the National Provider Identifier number (NPI) that is on file with us? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please provide former NPI (the NPI Colorado Access has on file):</i>
<i>If yes, please provide new/current NPI:</i>
Effective date:

ENTITY NAME

Are you changing the legal name that is on file with us? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please provide new legal name:</i>
Effective date:
Are you changing the Doing Business As (DBA) name on file with us? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please provide new Doing Business As (DBA) name:</i>
Effective date:

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CLINIC ADDRESS INFORMATION

Are you adding an additional service address? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes, please provide additional service address below</i>		
Clinic name:		
Clinic address:		
City:	State:	County:
Zip code:	Phone:	Fax:
NPI:	<input type="checkbox"/> Billing	<input type="checkbox"/> Service <input type="checkbox"/> Both
Tax ID:		
Effective date:		

CLINIC ADDRESS CHANGE INFORMATION

Are you changing the current service address? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is your clinic moving to a new location? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes, please provide new service address below</i>		
Clinic name:		
Clinic address:		
City:	State:	County:
Zip code:	Phone:	Fax:
NPI:		
Tax ID:		
Effective date:		

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REMIT ADDRESS INFORMATION

Are you changing the current remit address? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>(If changing your remit address, a W-9 is also required)</i>		
<i>If yes, please provide new remit address below</i>		
Remit address:		
City:	State:	County:
Zip code:	Phone:	Fax:

If there are multiple providers affected, please attach a list of names and their NPI numbers.

Please have the authorized signatory sign and date this form to affirm the updates noted are accurate and complete.

Form completed by: _____

Date: _____

Title: _____