PROVIDER NOTIFICATION OF CHANGE

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

TAX INDENTIFICATION INFORMATION

Are you changing the **Tax Identification Number (TIN)** that is on file with us? ☐ Yes ☐ No
*If yes, please provide **former TIN** (the TIN Colorado Access has on file):*
*If yes, please provide **new/current TIN**:*
Effective date:

NPI NUMBER INFORMATION

Are you changing the **National Provider Identifier number (NPI)** that is on file with us? ☐ Yes ☐ No
*If yes, please provide **former NPI** (the NPI Colorado Access has on file):*
*If yes, please provide **new/current NPI**:*
Effective date:

ENTITY NAME

Are you changing the **legal** name that is on file with us? ☐ Yes ☐ No
*If yes, please provide new **legal** name:*
Effective date:
Are you changing the **Doing Business As (DBA)** name on file with us? ☐ Yes ☐ No
*If yes, please provide new **Doing Business As (DBA)** name:*
Effective date:

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CLINIC ADDRESS INFORMATION

Are you adding an **additional** service address? ☐ Yes ☐ No			
*If yes, please provide **additional service address** below*			
Clinic name:			
Clinic address:			
City:		State:	County:
Zip code:	Phone:		Fax:
NPI:	☐ Billing	☐Service	☐Both
Tax ID:			
Effective date:			

CLINIC ADDRESS CHANGE INFORMATION

Are you changing the **current** service address? ☐ Yes ☐ No			
Is your clinic **moving** to a new location? ☐ Yes ☐ No			
*If yes, please provide **new service address** below*			
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? ☐ Yes ☐ No			
(If changing your remit address, a W-9 is also required)			
If yes, please provide ***new remit address*** *below*			
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: ______________________________