PHYSICAL AND OCCUPATIONAL THERAPY PROVIDER DEMOGRAPHIC CHANGE of INFORMATION FORM
For NEW OR ADDITIONAL PRACTICE SITES/LOCATION(S): Please Call 888-257-4353, OPTION # 1, TO Apply
PLEASE SUBMIT THIS FORM ONLY IF YOU ARE AN ORTHONET PROVIDER WITH USFHP
IN NY, NJ, PA or CT (Fairfield, Litchfield or New Haven County)
FOR ANY OTHER HEALTH PLANS or HOSPITALS PLEASE CONTACT THE HEALTH PLANS DIRECTLY

Provider ID#_____

Please submit in advance of effective date (No Retro dates): Updates may take 10-14 days to process.

If Changing TIN#, DBA or LEGAL Name - PLEASE SUBMIT W-9 with this completed form.
If Changing TIN#, DBA or Legal name - is this a Change in Ownership? Yes or No

NOTE for change of TIN: You will be contacted to sign a NEW Agreement BEFORE this request can be completed.

[ ] **This Office is/will be SOLD *Effective Date**_____

[ ] **This Office is/will be CLOSED *Effective Date**_____ **(only check off if no address change)**

***Required PREVIOUS PRACTICE ADDRESS:**		
Through Date_____/_____/_____	Tax ID#	
Legal Name:		
D/B/A Name:		
Address:		
City:	State:	Zip:

***Required NEW PRACTICE ADDRESS:**		
Effective Date_____/_____/_____	Tax ID#	Group NPI:
Legal Name:		
D/B/A Name:		
Address:		
City:	State:	Zip:
Phone:	Fax:	
Office Email:		Credentialing Email:

***Required NEW MAILING/CORRESPONDENCE ADDRESS:**		
Address:		
City:	State:	Zip:
Phone:	Fax:	

***Required NEW BILLING/CHECK/REMITTANCE ADDRESS:**		
Address:		
City:	State:	Zip:

List other Health Care Providers that practice in this office (Attach additional Sheet if Necessary)				
Name	License Type	NPI Number	Medicaid#	Current Provider for OrthoNet/Optum

Requested By (PRINT clearly):_____ **Title:** _____

Contact Phone/Ext: _____ **Date:** _____

***IMPORTANT: *Please be sure to send your changes to**
Provider Data Management Department at:

Fax: (888) 626–1701

OR
Email: network_PhysicalHealth@optum.com

For any questions regarding these changes, please call Provider Services at:
(800) 873 - 4575