ORTHONET PHYSICAL THERAPY & OCCUPATIONAL THERAPY "CONTRACTED" PROVIDER 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 AETNA in CT &/or USFHP in NY, NJ or CT(Fairfield, Litchfield or New Haven County)

FOR ANY OTHER HEALTH PLANS OF HOSPITALS PLEASE CONTACT THE HEALTH PLAN DIRECTLY. Change Effective Date: / / OrthoNet 7 Digit 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: 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) **CURRENT/OLD PRACTICE ADDRESS:** D/B/A Name: Legal Name: Address: State: City: County: Zip: Tax ID #: Phone: Fax: **CORRECT PRACTICE Address:** D/B/A Name: Legal Name: Address: City: State: County: Zip: Phone: Fax: Tax ID #: **Use Correct Practice Address above as Billing Address also** [] Use Correct Practice Address above as Mailing/Correspondence Address also **CURRENT/OLD BILLING or MAILING ADDRESS: (Circle one or both)** D/B/A Name: Address: City: County: State: Zip: Tax ID #: Phone: Fax: **CORRECT BILLING or MAILING/Correspondence ADDRESS: (Circle one or both)** D/B/A Name: Address: City: State: County: Zip: Phone: Fax: Tax ID #: *Current Cred Contact Name: *Current Email address: Requested By (PRINT clearly): Title: **Contact Phone/Ext:**

*IMPORTANT: *Please be sure to fax your changes to the Credentialing Department at <u>914-323-9307</u>. For any questions regarding these changes, please call Credentialing at 1-800-372-8922.