OrthoNet

CHANGE of INFORMATION FORM ONLY.
PLEASE COMPLETE - INCOMPLETE FORMS WILL NOT BE PROCESSED.

*********THIS FORM SHOULD NOT BE USED FOR NEW OR ADDITIONAL LOCATIONS**
Please Call 888-257-4353, OPTION # 1 , to Apply for the NEW OR ADDITIONAL LOCATION(S)*****

PLEASE SUBMIT ONLY IF YOU ARE AN ORTHONET THERAPY CONTRACTED PROVIDER FOR AETNA, CIGNA, USFHP & (HUMANA for KY only) (NOT Including HOSPITALS)
FOR ANY OTHER HEALTH PLANS YOU NEED TO CONTACT THE HEALTH PLAN DIRECTLY.

Effective Date of Change (s): _____/_____/_____ OrthoNet 7 Digit Provider #: _____

CURRENT/OLD PRACTICE ADDRESS:			
D/B/A Name:			
Legal Name:			
Address:			
City:	State:	County:	Zip:
Phone:	Fax:	Tax ID #:	

CORRECT PRACTICE Address :			
D/B/A Name:			
Legal Name:			
Address:			
City:	State:	County:	Zip:
Phone:	Fax:	Tax ID #:	

[ ] Also use Current Address above as Correspondence/Mail Address

CURRENT/OLD BILLING or MAILING ADDRESS : (Circle one or both)			
D/B/A Name:			
Legal Name:			
Address:			
City:	State:	County:	Zip:
Phone:	Fax:	Tax ID #:	

CORRECT BILLING or MAILING ADDRESS : (Circle one or both)			
D/B/A Name:			
Legal Name:			
Address:			
City:	State:	County:	Zip:
Phone:	Fax:	Tax ID #:	

If TIN# changed, is it a change of ownership? Yes No **(IF CHANGING TIN# - PLEASE SUBMIT W-9 with this form)**	
Credentialing Contact Name:	**Email address:**

Requested By (PRINT clearly) : _____ Title: _____Phone:_____ Date: _____

***IMPORTANT: *Please be sure to fax your changes to the Credentialing Department at 914-683-8415. Any questions regarding these changes, feel free to call us at: 1-800-372-8922.**
Please submit in advance of effective date; as updates may take 10-14 days to process.

ADDITIONAL NOTES: _____

Revised 2/10, 1/11, 7/11, 2/12