PHYSICAL & 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 AETNA in CT &/or USFHP in NY, NJ, PA or CT (Fairfield, Litchfield or New Haven County)

FOR ANY OTHER HEALTH PLANS or HOSPITALS PLEASE CONTACT THE HEALTH PLAN 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:		
Though 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