Prominence℠
Health Plan

Provider Demographic Change Form

Provider Name: _____

Medicare Number: _____

Select all that apply to the change request:

- ❑ Tax ID Number
- ❑ Group Name
- ❑ Provider Name
- ❑ Phone Number
- ❑ Fax Number
- ❑ Physical Address
- ❑ Mailing Address
- ❑ Billing/Remittance Address
- ❑ Other – Please describe change below

Previous Demographic Information:

Tax ID Number: _____

Group Name: _____

Address (street, city, state, zip): _____

Phone Number: _____

New Demographic Information:

New Tax ID Number: _____ (please attach a completed W-9)

New Group Name: _____

Provider Name Change: _____

New Phone Number: _____

New Fax Number: _____

New Physical Address (street, city, state, zip): _____

New Mailing Address (street, city, state, zip): _____

New Billing Address (street, city, state, zip): _____

Other Information or Special Instructions: _____

Return Completed Form to: Provider Relations at 775.770.9006