

**NEW AVENUES EAP/ MIDWEST BEHAVIORAL HEALTH NETWORK
PROVIDER INFORMATION UPDATE FORM**

Section A. GENERAL INFORMATION

Group/Practice Name		<input type="checkbox"/> Solo Practice	<input type="checkbox"/> Group Practice
Practice Tax ID Number		<input type="checkbox"/> EIN	<input type="checkbox"/> SSN
Provider First Name	MI	Last Name	Licensure

Section B. REASON FOR SUBMITTING FORM

<input type="checkbox"/> Practice Name Change	<input type="checkbox"/> Billing Name Change	<input type="checkbox"/> Adding Location
<input type="checkbox"/> Practice Address Change	<input type="checkbox"/> Billing Address Change	<input type="checkbox"/> Practice Hours Change
<input type="checkbox"/> Practice Phone Change	<input type="checkbox"/> Billing Phone Change	<input type="checkbox"/> Additional Certification Update
<input type="checkbox"/> Practice Fax Change	<input type="checkbox"/> Billing Fax Change	<input type="checkbox"/> Tax ID Change
<input type="checkbox"/> Practice Email Change	<input type="checkbox"/> Billing Email Change	<input type="checkbox"/> Deleting Provider from Group
<input type="checkbox"/> Delete Practice Location	<input type="checkbox"/> Delete Billing Location	<input type="checkbox"/> Other, please describe

***Date Required* Effective Date of Add, Change or Deletion** ___/___/___

Please give brief description of change:

Section C. Practice Address Required * Note, If changing address put current address here (old address). Complete billing address if different from practice address.

Previous Practice Name	Previous Billing Tax ID
Previous Practice Address	Previous Billing Address
City State Zip	City State Zip
County	County
Phone Number Fax () - () - After Hours/ER Number () - <input type="checkbox"/> Pager <input type="checkbox"/> Answering Svc. <input type="checkbox"/> Cell <input type="checkbox"/> Home Email Address	Phone Number Fax () - () - After Hours/ER Number () - <input type="checkbox"/> Pager <input type="checkbox"/> Answering Svc. <input type="checkbox"/> Cell <input type="checkbox"/> Home Email Address

Section D. Practice Address Note* If Changing address, place new address here.

New Practice Name	New Practice Tax ID
New Practice Address	New Billing Address
City State Zip	City State Zip
County	County
Phone Number Fax () - () - After Hours/ER Number () - <input type="checkbox"/> Pager <input type="checkbox"/> Answering Svc. <input type="checkbox"/> Cell <input type="checkbox"/> Home Email Address	Phone Number Fax () - () - After Hours/ER Number () - <input type="checkbox"/> Pager <input type="checkbox"/> Answering Svc. <input type="checkbox"/> Cell <input type="checkbox"/> Home Email Address

Practice Hours						
Mon.	Tue.	Wed.	Thur.	Fri.	Sat.	Sun.

Section E. Additional Office Locations

Second Practice Name			Second Practice Tax ID# _____ <input type="checkbox"/> EIN <input type="checkbox"/> SSN			
Second Practice Address			Second Billing Address			
City	State	Zip	City	State	Zip	
County			County			
Phone Number () _____ - _____		Fax () _____ - _____		Phone Number () _____ - _____		Fax () _____ - _____
After Hours/ER Number () _____ - _____			After Hours/ER Number () _____ - _____			
<input type="checkbox"/> Pager <input type="checkbox"/> Answering Svc. <input type="checkbox"/> Cell <input type="checkbox"/> Home			<input type="checkbox"/> Pager <input type="checkbox"/> Answering Svc. <input type="checkbox"/> Cell <input type="checkbox"/> Home			
Email Address			Email Address			

Practice hours

Mon.	Tue.	Wed.	Thur.	Fri.	Sat.	Sun.
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Third Practice Name			Third Practice Tax ID# _____ <input type="checkbox"/> EIN <input type="checkbox"/> SSN			
Third Practice Address			Third Billing Address			
City	State	Zip	City	State	Zip	
County			County			
Phone Number () _____ - _____		Fax () _____ - _____		Phone Number () _____ - _____		Fax () _____ - _____
After Hours/ER Number () _____ - _____			After Hours/ER Number () _____ - _____			
<input type="checkbox"/> Pager <input type="checkbox"/> Answering Svc. <input type="checkbox"/> Cell <input type="checkbox"/> Home			<input type="checkbox"/> Pager <input type="checkbox"/> Answering Svc. <input type="checkbox"/> Cell <input type="checkbox"/> Home			
Email Address			Email Address			

Practice hours

Mon.	Tue.	Wed.	Thur.	Fri.	Sat.	Sun.
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Section F. Comments

Section G. Signature

 Provider Signature _____
 Date

Please return this form to: New Avenues, P.O. Box 360, South Bend, IN 46624

Please send completed form together with current copies of the following:

- Malpractice Liability Insurance Face Sheet \$1,000,000/\$3,000,000 minimum requirement.
- W-9 Tax Form, for each practice if using multiple Tax ID numbers.

For internal use only
 Last Credentialing Date _____ Original Credentialing Date _____ Contract Signed _____ Update entered _____