To:	Hamaspik Managed Care
Attn:	Provider Relations Dept.
Fax To:	(845) 503-1907
Email To:	ProviderRelations@hamaspikchoice.org

Date: _____

INFORMATION CHANGE REQUEST

From: *(please include provider name, address, telephone no.)*

NPI: _____

Requested change:

- ☐ Billing/Remit To Address
- ☐ Tax Identification Number (must include a W-9 form)
- ☐ Practice Office Address/Telephone
- ☐ Other

Please specify the change below and indicate **effective date** for the change:

Requested by:

Signature:		**Date:**	
Print Name:		**Title:**	

========== Hamaspik Use Only ==========

Confirmed by: _____

Action: _____