

Provider or Practitioner Name: _____



Provider Demographic Update Form

PLEASE INCLUDE W9 FORM AND IF APPLICABLE, PHYSICIAN ROSTER/PRACTICE LOCATIONS

Practitioner Information:

Last Name:	First Name:	NPI:	Tax ID:
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Or:

Group/Organization Name:	NPI:	Tax ID:
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Type of change: update or additions

Address New provider/group name Phone Add new location Specialty Tax ID NPI

Effective date of change: _____

Effective date of Additions: _____

PCP Panel (IM,FP,PEDs) Yes <input type="checkbox"/> No <input type="checkbox"/>	Accepting New Patients: Yes <input type="checkbox"/> No <input type="checkbox"/>	EPSDT Certified: Yes <input type="checkbox"/> No <input type="checkbox"/>
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> N/A <input type="checkbox"/>	Board Certified: Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Listed in the Directory: Yes <input type="checkbox"/> No <input type="checkbox"/>
Languages (Please List):	Ages Served:	Office Hours:
EDI (HCFA/UB): Yes <input type="checkbox"/> No <input type="checkbox"/>	More information on Electronic Claims: Yes <input type="checkbox"/> No <input type="checkbox"/>	

NPI Update: Only complete the fields below where the current information we have on file is changing.

Old NPI	New NPI
NPI Number:	NPI Number:

Old Physical location address:

Street Address:		
Suite Number:		
City:	State:	Zip:
Phone number:	Fax number:	

New Physical location address:

Street Address:		
Suite Number:		
City:	State:	Zip:
Phone number:	Fax number:	

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Old Remit/payable to address:

Street Address:		
Suite Number:		
City:	State:	Zip:

New Remit/payable to address:

Street Address:		
Suite Number:		
City:	State:	Zip:

Old Mailing address:

Street Address:		
Suite Number:		
City:	State:	Zip:

New Mailing address:

Street Address:		
Suite Number:		
City:	State:	Zip:

Old Information: Please complete the fields below with your updated information.

New group/organization name:	
New provider name:	
Tax ID Number:	NPI:

New Information: Please complete the fields below with your updated information.

New group/organization name:	
New provider name:	
Tax ID Number:	NPI:

Please provide us with your current information so that we can better serve you. You can email this completed form to providerdatamanagement@mpcmedicaid.com or mail/fax it to:

Maryland Physicians Care
Providers Relations
1201 Winterson Rd., Suite 400
Linthicum, MD 21090-2256
Phone: (800) 953-8854 (follow prompts to Provider Relations)
Fax: (833) 694-1519

www.mpcmedicaid.com / www.marylandhealthinsuranceplan.state.md.us