

**Change of Information Form**

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**Date**:

|  |  |
| --- | --- |
| **Provider Information** | |
| Provider/Group Name: |  |
| Contact Information: |  |
| Provider  Specialty: |  |
| Provider NPI: |  |
| Billing NPI: |  |
| Provider Tax ID #: |  |

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| --- | --- |
| **Please check Information requiring Change:** | |
| ☐ | Change of Office Address |
| ☐ | Change of Phone Number |
| ☐ | New Location |
| ☐ | Open Panel |
| ☐ | Close Panel |
| ☐ | Change of Tax ID# (W-9 Required) |
| ☐ | Change of Billing Address (W-9 Required) |
| ☐ | Current Information (Include phone number & Email Address) |
| ☐ | New/Updated Information (Include phone number & Email Address |

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| **Additional Information:** | |
| What is the age range of patients seen in your office/location? |  |
| Office Hours, including evenings and weekends |  |

|  |  |
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| **Provider Termination:** | |
| Effective Date of Termination: |  |
| Contact Person Name: |  |
| Contact Phone Number: |  |
| Contact Email Address: |  |

**Please include the following: (1)** W9 **(2)** all other documents supporting the request for the change.