**Change of Information Form**

Phone: 1-866-946-4458 | Fax: 1-844-918-4458

provider.services@myzinghealth.com

**Date**:

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| **Provider Information** |
| Provider/Group Name: |  |
| Contact Information: |  |
| ProviderSpecialty: |  |
| 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.