Optum Oregon
Provider Group/Practitioner Change Form

Please use this form for demographic changes or to update your NPI information. Please make sure that all the information is complete as we cannot process incomplete forms. Please email your completed form to **credentialingpnw@optum.com.**

Select the changes being submitted. Then only complete the necessary corresponding section(s).	
☐ Practice Name ☐ Practitioner Name ☐ Tax ID Number ☐ Office Location/Address ☐ Billing Address ☐ Correspondence Address	☐ Telephone Number ☐ Fax Number ☐ Email Address ☐ Adding New Provider(s) ☐ Terminated Provider(s)

Section II – Group Demographics

Practice/organization name: _____

Current Tax ID (TIN): _____

National Provider Identifier (NPI): _____ Date issued:

Basis for NPI (applies to organizations only, select only 1 per NPI):

☐ Provider Name ☐ Tax ID only (entity whose name is in the W-9 form)
☐ License Number ☐ NUCC Taxonomy Code ☐ Place of service address ☐ Department
☐ Other (please explain)

☐ Please check here if you have multiple NPIs representing your practice or organization.

Section III - Practice/Organization change

☐ New tax ID number is: _____ Effective:
(please attach a copy of the W-9)

☐ We have moved. Our new address is effective:
This new address is a:

☐ Practice address ☐ Billing address ☐ Both practice & billing address
☐ Correspondence address

Should this new address be in the directory? ☐ Yes ☐ No

New	Old
Address:	Address:
Telephone:	Telephone:
Fax:	Fax:
Email:	Email:

☐ We have changed our practice name to: _____
Effective:
Change pertains to all practitioners under the Tax ID (TIN): _____
Specify physicians/health care providers affected by the change:

Section IV - Adding a New Practitioner

☐ These physicians/health care providers have joined our practice (please attach a copy of the W-9).

Name: _____ Degree: _____ E-mail _____
Practice address:
_____

Specialty: _____ Individual NPI: _____
Effective Date:

Name: _____ Degree: _____ E-mail _____
Practice address:
_____

Specialty: _____ Individual NPI: _____
Effective Date:

Name: _____ Degree: _____ E-mail _____
Practice address:
_____

Specialty: _____ Individual NPI: _____
Effective Date:

☐ Check this box if you do not have a private office and only see patients at the hospital

Section V - Terming a Practitioner

☐ These physicians/health care providers have left our practice.

Name: _____Degree: _____
Practice Address: _____
Specialty: _____ IndividualNPI: _____
Effective Date:
Reason for Leaving: _____

Name: _____Degree: _____
Practice Address: _____
Specialty: _____ IndividualNPI: _____
Effective Date:
Reason for Leaving: _____

Name: _____Degree: _____
Practice Address: _____
Specialty: _____ IndividualNPI: _____
Effective Date:
Reason for Leaving: _____

Name of individual completing this form: _____

Signature_____ Date:

Telephone: _____ E-mail: _____