Preferred Care Partners
A UnitedHealthcare Company

PREFERRED CARE NETWORK
A UnitedHealthcare Company

Provider Demographic Change Request Form

INSTRUCTIONS: (Please type or print legible to avoid processing delays)

- ✓ Complete entire form, regardless of the type of changes you are requesting.
- ✓ Be sure to include a W-9. Changes will not be made unless a W-9 is received.
- ✓ Sign and date were indicated.
- ✓ Fax or Email completed form and W-9 to Network Management Services: Fax: 1-888-659-0619
  Email: pcpnms-inhouse@uhcsouthflorida.com

Current Provider Information

Provider Name: _____ Tax ID: _____

Specialty: _____ Group NPI: _____ NPI: _____

Provider Change Information (This change affects)

☐ Group Practice ☐ Individual Provider ☐ Institution / Facility Date change will effect: _____

Type of Change (Please check all that apply)

☐ Address Change – Practice / Facility Location	☐ (FAX) Number Change – Practice	☐ NPI# Add / Change (Specify Group or Individual)
☐ Address Change – Billing Address	☐ Add (FAX) Number	☐ TIN or SSN Number Add / Change
☐ Address Change – Mailing Location	☐ (FAX) Number Change – Billing	☐ Add a Provider to Practice
☐ Telephone Number Change – Practice Location	☐ (FAX) Number Change – Mailing	☐ Medicaid - Medicare Provider Number Add /Change
☐ Telephone Number Change – Billing Location	☐ E-Mail Address Add / Change	☐ Taxonomy Codes (Group or Individual) Add / Change
☐ Telephone Number Change – Mailing Location	☐ Location Add / Remove	☐ Other Add/Change

NEW Demographic Information

(Form W-9 must be submitted with all Tax ID

NEW Service Information (If more than one location, attach Primary service ☐ Yes ☐ No

Individual Name: _____ Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

Tax ID: _____ Group NPI: _____ NPI: _____

OLD Demographic

☐ CORRECT ☐ CHANGE

(Form W-9 must be submitted with all Tax ID

OLD Service Information (If more than one location, attach Primary service ☐ Yes ☐ No

Individual Name: _____ Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

Tax ID: _____ Group NPI: _____ NPI: _____

Print Name and Title of Authorized Signature: _____

Telephone: _____ Email Address: _____

Authorized Signature: _____ Date: _____