Affinity Health Plan

PROVIDER INFORMATION UPDATE

Instructions: Please complete this form to indicate any addition/changes to your office information. FAX your completed form to Affinity Health Plan: 718-794-7808.

SECTION A: PLEASE COMPLETE THIS SECTION REGARDLESS OF THE CHANGE YOU ARE INDICATING BELOW.

Today's date: _____ **Are you accepting new patients?** Yes ☐ No☐

Provider name: _____

Provider site/practice name: _____

Provider e-mail address: _____

Best phone number (for patients to make appointments): (____)_____

Fax Number: (_____)_____

SECTION B: ADD/DELETE LOCATION

Are you <u>adding</u> or <u>moving</u> to a new location, or closing down one? If so, please indicate below:		
☐ ADD ☐ DELETE ☐ MOVED		
Address (include suite/floor):		
City:	State:	Zip Code:
☐ ADD ☐ DELETE ☐ MOVED		
Address (include suite/floor):		
City:	State:	Zip Code:
☐ ADD ☐ DELETE ☐ MOVED		
Address (include suite/floor):		
City:	State:	Zip Code:
☐ ADD ☐ DELETE ☐ MOVED		
Address (include suite/floor):		
City:	State:	Zip Code:

SECTION C: FINANCIAL ADDRESS

Complete this section to indicate a new financial (business office) address:		
Address:		
City:	State:	Zip Code:

SECTION D: BILLING & TAX ID INFORMATION

Individual NPI Number:
Individual Tax ID/EIN:
Taxonomy Code (associated with Individual NPI Number):
CMS Certification Number (CCN) for Medicare:

Group NPI Number:
Group Tax ID/EIN:
Taxonomy Code (associated with Group NPI Number):
CMS Certification Number (CCN) for Medicare: