

## Provider Data Change Request Form

*Fill out this top section completely and any section where your information has changed. Complete one data sheet per Provider. Please make copies of this form as needed. E-mail completed form to [AC-ProviderContracting@American-Community.com](mailto:AC-ProviderContracting@American-Community.com) or you can fax to (734) 853-2290.*

Tax ID #: \_\_\_\_\_ NPI #: \_\_\_\_\_

Provider Last Name \_\_\_\_\_ Provider First Name \_\_\_\_\_ Provider Middle Name \_\_\_\_\_

Provider's Degree: \_\_\_\_\_ Language Spoken (Other than English): \_\_\_\_\_ Gender:  Male  Female

Affiliated Hospitals

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Check here if you are a PCP (Primary Care Provider) IPA/PHO Name: \_\_\_\_\_

Primary Taxonomy Code: \_\_\_\_\_ Primary Specialty: \_\_\_\_\_

Secondary Taxonomy Code: \_\_\_\_\_ Secondary Specialty: \_\_\_\_\_

### Office Location

**Check all that apply:**  Use as Payment (Remit To) Address  
 Not accepting new Patients  Do not print in Directory

Practice Name: \_\_\_\_\_  
 Street Address (1): \_\_\_\_\_  
 Street Address (2): \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_

Contact Person  
 Last Name: \_\_\_\_\_  
 First Name: \_\_\_\_\_  
 Title or Position: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 E-mail \_\_\_\_\_

### Additional Office Locations

**Check all that apply:**  Use as Payment (Remit To) Address  
 Not accepting new Patients  Do not print in Directory

Practice Name: \_\_\_\_\_  
 Street Address (1): \_\_\_\_\_  
 Street Address (2): \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_

**Check all that apply:**  Use as Payment (Remit To) Address  
 Not accepting new Patients  Do not print in Directory

Practice Name: \_\_\_\_\_  
 Street Address (1): \_\_\_\_\_  
 Street Address (2): \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_

### Payment (Remit To) Address (If different than Office Location)

Practice Name: \_\_\_\_\_  
 Street Address (1): \_\_\_\_\_  
 Street Address (2): \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_

Contact Person  
 Last Name: \_\_\_\_\_  
 First Name: \_\_\_\_\_  
 Title or Position: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 E-mail \_\_\_\_\_