Healthy Mississippi, Inc.
10 Canebrake Blvd, Ste 100
Flowood, MS 39232

Provider Demographic Change Form

Complete this form when requesting a change to your billing, practice, and demographic information for a solo provider or group. Include all information related to your request. Incomplete forms or those missing supporting documents will not be processed.

Current Provider Information

Full Name: _____

Gender: ❑ Male ❑ Female

Medical Designation (Please select one option below)

❑ MD ❑ DO ❑ PA ❑ NP ❑ Other: _____

NPI Number: _____ Tax ID: _____

Contact Phone: _____ Contact Email: _____

Effective Date of Change: _____

Note: The effective date should not be greater than 60 days from the submission of this form.

Type of Change (Check all that apply)

❑ TIN Add (Requires a copy of W-9 Form) Effective Date: _____

❑ TIN Change (Current and New TINs are both required)

Current TIN _____

New TIN _____ Effective Date: _____

❑ Name Change (Group or Provider) _____

❑ Hospital Affiliation add / change: _____

❑ No longer accepting patients. Effective Date: _____

Location Information

_____

_____

Primary Location Change

Please attach an additional form for additional location change request.

Effective Date: _____

Provider Name: _____ NPI: _____

Primary / Group TIN: _____ Primary / Group NPI: _____

New Primary Practice Location Address:

Practice Name: _____
Address: _____ Suite #: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

Is this the primary mailing address? ❑ Yes ❑ No

Is this location wheelchair accessible? ❑ Yes ❑ No

Do you see patients on a regular and consistent basis, at least one day per week? ❑ Yes ❑ No

Is there non-English speaking office staff available at this location? ❑ Yes ❑ No

What are the non-English languages spoken by office staff or interpreters?

_____

_____

Please list your hours of operation for each day at this location:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Should this location be included in the Provider Directory? ❑ Yes ❑ No

Is the payment address the same as: ❑ Practice ❑ Other

Remittance / Payment Adress:
Address: _____
City: _____ State: _____ Zip Code: _____

Mailing Adress:
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Please return the completed form to healthymsplan@healthy-ms.com