



Healthy Mississippi, Inc.
PO Box 21069
Eagan, MN 55121
1-833-201-6413 TTY: 711

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



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Primary Location Change

Please attach an additional form for an 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 Address:

Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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