Paramount Health Care
Provider Information Change Form

SAVE this form to your computer, then complete all applicable fields for the update. When finished, print, sign (below) and return to Paramount Health Care by:

Fax – 567-585-9403
Email – ProviderRelations.Paramount@MedMutual.com
Mail – Paramount Health Care, PO Box 928, Toledo, OH 43697-0928

Provider Name_____ **NPI**_____**TAX ID**_____
(Please attach a list of additional providers & NPIs, and check all boxes applicable)

Group Name _____ Contact Person (print) _____
Job Title _____ Contact Phone _____
Fax_____ **Email**_____
Contact Signature _____Todays Date_____

Effective Date of Change(s) _____

☐ **NEW Office Location or Contact Information** (attach additional pages if needed)

☐ **New location/contact info** ☐ **Primary office** ☐ **Alternate Office**

Street Address _____ Ste #_____

City _____ State _____ Zip _____

New Phone # _____ New Fax # _____

New Office Hours _____

Publish in directories? ☐ Yes ☐ No

☐ **PREVIOUS Office Location or Contact Information**

☐ **No longer practicing here** ☐ **Primary office** ☐ **Alternate Office**

Street Address _____ Ste #_____

City _____ State _____ Zip _____

Previous Phone # _____ Previous Fax # _____

☐ **Billing-Remit Address / Tax ID / Group Name Changes** (attach W-9 form)

New Tax ID _____ (30-day notice required) TIN Effective Date _____

New Group Name _____

Street Address or PO Box _____

City _____ State _____ Zip _____

New Phone # _____ New Fax # _____

☐ **Termination** Effective Date _____ Reason _____

☐ **PCPs Only – Changes**

Accepting new patients? ☐ Yes ☐ No

☐ **Change in Hospital Affiliation** ☐ Add hospital ☐ Remove hospital

Hospital _____