Click to Clear Form

Provider Demographic Change Form

Steps for Submission:

This form is to be used when a practitioner has a change in their practice affiliation information

1. Complete the Provider Demographic Change Form with the most current information and attach a W-9 and Certificate of Insurance, if applicable.
2. E-mail the form to *i*Care's Provider Updates (ProviderUpdates@icarehealthplan.org) and *i*Care's Operations Department (OperationsProviderMaintenance@icarehealthplan.org) or fax the form to 414-272-5618.

Reason(s) for Submission - REQUIRED: ○ **Add** ○ **Remove** ○ **Change**

Select all that apply:

- ☐ **NPI**
- ☐ **Tax ID**
- ☐ **Name**
- ☐ **Practice/Physical Location**
- ☐ **Corporate/Mailing Location**
- ☐ **Specialty**
- ☐ **Contact**
- ☐ **Office Hours**
- ☐ **Billing Address**

Provider Demographics on File - REQUIRED:

Practice/Practitioner Name:

National Practitioner Identifier (NPI):

Tax Identification Number (TIN):

New Provider Demographics: (check box for Practice or Practitioner)

**iCare is required to report demographic information of providers who serve enrollees to demonstrate non-discriminatory practices. To comply with this requirement, we encourage you to provide the information below. This information is voluntary. iCare does not and shall not discriminate or base credentialing decisions on the basis of the practitioner's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes.*

- ○ Practice
- ○ Practitioner
- ☐ Male
- ☐ Female

Provider Name: **Effective Date:**

National Practitioner Identifier (NPI):

Tax Identification Number (TIN):

Licensure: **Medicaid:** **Medicare:**

Specialty: **Accreditation:**

cont'd **New Provider Demographics:**

Language(s):

Practice/Corporate Address

☐ **New Address**
☐ **Terminate Location**
☐ **Primary & Acute**
☐ **Behavioral Health**
☐ **Long Term Care**
☐ **Handicap Accessible**
☐ **Primary Location**
☐ **ADH Accessible**
☐ **Accepting New Patients**

Street: **Suite:**

City: **State:** **Zip:**

E-Mail: **Website:**

Telephone: **Fax:** **Office Hours:**

Do you offer Telephonic Telehealth? ◯ **Yes** ◯ **No**

Do you offer video Telehealth? ◯ **Yes** ◯ **No**

Billing Address

*If your billing information has changed but you are not sure you have submitted an updated W-9, please submit one with this form

☐ **New Address**
☐ **Terminate Address**
☐ **Electronic Billing**

Street: **Suite:**

City: **State:** **Zip:**

E-Mail:

Telephone: **Fax:** **Office Hours:**

Contact Information

Contact Name:

Contact E-Mail:

Telephone: **Fax:**

Electronic Signature: **Date:**

Type of Contact from Contact Information (above)

Billing Contact

Comments (please list additional affiliations if applicable):

If you prefer to complete this form manually, please submit to:

Independent Care Health Plan
Attn: Network Development
1555 N Rivercenter Dr, Suite 206
Milwaukee, WI 53212
Fax: 414-272-5618