INDEPENDENT CARE HEALTH PLAN

# Provider Affiliation 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 Affiliation Change Form with the most current information and attach a W-9 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 please fax the form: 414-272-5618.**

Reason(s) for Submission (required):

☐ Adding Provider To Practice ☐ Terminating Provider From Practice

**Provider Demographics On File (Required):**

Practice/ Name:

Tax Identification Number:

National Practitioner Identifier (NPI):

**New Practitioner Demographics:**

☐ Male
☐ Female

Practitioner Name:

Effective Date:

National Practitioner Identifier (NPI):

Tax Identification Number (Tax ID):

Licensure:

Medicaid:

Medicare:

Specialty:

Accreditation:

**Practice/Corporate Address**

☐ New Address ☐ Handicap Accessibility

☐ Terminate Location ☐ Primary Location

Street: _____ Suite # _____

City: _____ State: _____ ZIP: _____

E-Mail: _____

Telephone: _____ Fax: _____ Office Hours: _____

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**Billing Address**

☐ New Address ☐ Electronic Billing

☐ Terminate Address

Street: _____ Suite # _____

City: _____ State: _____ ZIP: _____

E-Mail: _____

Telephone: _____ Fax: _____ Office Hours: _____

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**Contact Information**

Requestor Name: _____ Requestor E-mail: _____

Telephone: _____ Fax: _____

Electronic Signature: _____ Date: _____

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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, STE 206
Milwaukee, WI 53212
Fax: 414-272-5618