



Provider Demographic Change Form

INDEPENDENT CARE HEALTH PLAN

Steps for Submission:

This form is to be used when a practitioner or group has a change in their demographic information. If adding or deleting a practice location, please include a practitioner roster.

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

Reason(s) for Submission (required): Add Remove Change

Select all applicable:

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

Provider Demographics On File (Required):

Practice/Practitioner Name:

Tax Identification Number: National Practitioner Identifier (NPI):

New Provider Demographics (Check Box for Practice or Practitioner)

Practice Male
Practitioner Female

Provider Name: Effective Date:

National Practitioner Identifier (NPI): Tax Identification Number (Tax ID):

Licensure: Medicaid: Medicare:

Specialty: Accreditation:

Practice/Corporate Address

New Address

Handicap

Terminate Location

Accessibility

Primary Location

Street:

Suite #

City:

State:

ZIP:

E-Mail:

Telephone:

Fax:

Office Hours:

Billing Address

New Address

Electronic

Terminate Address

Billing

Street:

Suite #

City:

State:

ZIP:

E-Mail:

Telephone:

Fax:

Office Hours:

Contact Information

Requestor Name:

Requestor E-mail:

Telephone:

Fax:

Electronic Signature:

Date:

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