PHYSICIAN PRACTICE LOCATION & BILLING INFORMATION CHANGE FORM

Practice Location:

Practice Name (*if applicable*): _____

Current Office Address (*Please indicate if the current office is still current or closed if new office is added*)

Address: _____

Phone: _____ Fax: _____ Email: _____

Office Hours: _____

New Office Address

Address: _____

Phone: _____ Fax: _____ Email: _____

Office Hours: _____

Effective Date of Changes: _____

Additional Office Address (*If applicable*)

Address: _____

Phone/Fax: _____ Email: _____

Office Hours: _____

Effective Date of Changes: _____

New Billing Information: ***(Please attached your official Form W-9 Tax Identification Form)***

Name affiliated with Tax ID Name: _____

Doing Business As (DBA) (if applicable) _____

Payment/Billing Address: _____

Federal Tax I.D. # _____ **Ind NPI #** _____ **Grp NPI #** _____

Effective Date of Changes: _____

Physician Name (Please print): _____

Physician Signature: _____ **Date:** _____

Please return the form to AAMG/CCHCA Provider Relations Team
By Fax: (415) 216-0081 **By Email: Provider.Relations@aamgdoctors.com**

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