CENTRAL GEORGIA HEALTH NETWORK

(DEMOGRAPHIC FORM) Revised 8/4/2015

EFFECTIVE AS OF ____ / ____ / ____

Type of Notification **(Please check all that apply)**:

☐ Provider Joining Practice ☐ Provider Leaving Practice ☐ Add Provider Address ☐ Term Provider Address
☐ Opening New Office ☐ Closing Office ☐ New Billing Address ☐ Update Contact Information
☐ Other (Please Specify): _____

Provider: (for changes to provider only)

Last Name | First Name | Middle Name | Suffix | Degree | Provider NPI #

Providers Email Address | Specialty

Group Name:

Closing Office Address:

Office Address/Contact Information:

Please list new location information here. If adding more then one location, use additional office location sections on pg. 3

Street Address/Suite # | City | State | Zip | County

Medicare # _____ Medicaid # _____

( ) - Office Phone # ( ) - Office fax # Office Web-Site

Office Managers Name | Email Address | Tax ID #

Accepting New Patients: ☐ Yes ☐ No

Handicap Access: ☐ Yes ☐ No

Print in Directory: ☐ Yes ☐ No

Hospital/Office-based location: ☐ Hospital ☐ Office

Billing Address:

Street Address/Suite # | City | State | Zip | County

( ) - Billing Phone #

( ) - Billing fax #

Billing Managers Name

Email Address

Correspondence Address:

Street Address/Suite # | City | State | Zip | County

( ) - Correspondence Phone #

( ) - Correspondence fax #

Correspondence Contact Name

Correspondence Contact Email Address

Change Authorization:

Name: Title:

Date:

Comment:

Please indicate providers to be listed at this location or indicate that all providers are to be listed:

If applicable, please complete as many as needed for additional office locations

Additional ☐Office ☐Correspondence Address:

Street Address/Suite # City State Zip County

Medicaid #

( ) - ( ) -

Office Phone # Office fax # Office Web-Site

Office Managers Name Email Address Tax ID #

Print in Directory: ☐ Yes ☐ No

Additional ☐Office ☐Correspondence Address:

Street Address/Suite # City State Zip County

Medicaid #

( ) - ( ) -

Office Phone # Office fax # Office Web-Site

Office Managers Name Email Address Tax ID #

Print in Directory: ☐ Yes ☐ No

Additional ☐Office ☐Correspondence Address:

Street Address/Suite # City State Zip County

Medicaid #

( ) - ( ) -

Office Phone # Office fax # Office Web-Site

Office Managers Name Email Address Tax ID #

Print in Directory: ☐Yes ☐No