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 | Cell Phone #

Authorization By: (name/title)

Closing Office Address:

Office Address/Contact Information:

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