PROVIDER INFORMATION CHANGE FORM (PICF)

Please type or print and fax the completed form to
Provider Relations at (504) 849-6916.
Limit changes to one provider and location per form.

Effective Date of Change: ____________________________ Attachments: ☐ YES ☐ NO

Provider Type: ☐ ANCILLARY FACILITY ☐ HOSPITAL ☐ PHYSICIAN

Provider Specialty: _________________________________ Network Status: Contracted Non-Contracted

Provider Name: ____________________________________ Provider Title: ______________________________

Group Name: ______________________________________ Office Hours: _______________________________

Contact Person: ____________________________________ Contact Phone: _____________________________

Office Address: ______________________________________ Suite or Building Number: _____________________

City: _______________________________________ State: ____________________ ZIP: ______________________

Phone Number: _______________________________ Office Fax Number: _______________________________

Referral Fax Number: __________________________________

Billing Address: ____ Suite or Building Number: ___________________

City: _______________________________________ State: ____________________ ZIP: ______________________

Correspondence Address: __________________________________ Suite or Building Number: __________________

City: _______________________________________ State: ____________________ ZIP: ______________________

Update Tax ID Number(s): ____

Note: W-9 Form must be attached in order to change TIN(s).

Additional Comments: ____

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Please check all applicable changes:

☐ Billing Address ☐ Correspondence Address ☐ Tax ID Number(s) (include W-9)

☐ Office Address (temp or perm) ☐ Office Fax Number ☐ Referral Fax Number

☐ Additional Location (temp or perm) ☐ Telephone Number ☐ Practice Name

☐ Office Hours ☐ Other: ____

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