Texas Children's Health Plan

Provider Information Change Form

Please print clearly or type all of the information on this form. Mail or fax the completed form and any additional documentation to the address or the fax number at the bottom of the page. ***Include W9 in the submission.***

Check the box if the changes are for a PCP Provider with TCHP ☐	Date:
National Provider Identifier (NPI):	Provider Name:
Tax Identification Number (TIN):	Office Manager Name:
Name of Person filling out form:	Office Phone Number:

Type of Change Request (check all that apply) ***Address change must reflect attested NPI address.***

- ☐ Change of physical address, telephone, and/or fax number
- ☐ Change of billing/mailing address and/or Tax Information Number (TIN)
- ☐ Change/add secondary or additional addresses, telephone, and/or fax number
- ☐ Change of provider status (e.g., panel closing, capacity changes, and age acceptance)
- ☐ Change in hospital affiliation Y☐ N☐ Describe change
- ☐ Other (Explain)

Physical Address – The physical address cannot be a PO Box. ADA Compliant? Y☐ N☐

Clinic Name: Effective Date:

Street Address: City: State: Zip Code:

Telephone: Fax Number: Email:

Secondary Address ADA Compliant? Y☐ N☐

Clinic Name: Effective Date:

Street Address: City: State: Zip Code:

Telephone: Fax Number: Email:

Additional Address ADA Compliant? Y☐ N☐

Clinic Name: Effective Date:

Street Address: City: State: Zip Code:

Telephone: Fax Number: Email:

Tax Information – Tax Identification Number (TIN) and Name for the Internal Revenue Service (IRS)

Tax ID Number: Effective Date:

Exact name reported to the IRS for this Tax ID:

Billing/Mailing Address – All providers who make changes to the Billing/Mailing address must submit a copy of the W9 Form along with this form.

Street Address or Post Office: City: State: Zip Code:

REQUIRED FIELD – Billing Address Effective Date:

Other Provider Demographic Information – (fill out only if changes are required)

Languages spoken other than English:

Provider office hours by location:

Panel Status: ☐STAR ☐CHIP ☐Both Accepting (check one): ☐New Patients ☐Current Patients Only Effective Date:

Patient age range accepted by provider: Patient gender limitations: ☐Female ☐Male ☐Both

☐Telehealth ☐Telemedicine ☐Telemonitoring

Comments:

REQUIRED FIELD – SIGNATURE AND DATE ARE REQUIRED OR THE FORM WILL NOT BE PROCESSED.

Provider or Requestor signature:

Mail or fax the completed form to:

Texas Children's Health Plan
Provider and Care Coordination Dept.
PO Box 301011 WLS 8301
Houston, TX 77230-1011

or please FAX form to:
Provider Relations
832-825-8750

If you have any questions or concerns regarding this form, please do not hesitate to contact your Provider Relations Manager or Provider Relations at 832-828-1008. Thank you for being a provider with Texas Children's Health Plan.