

SUFFOLK HEALTH PLAN
PRACTICE INFORMATION CHANGE

Use this form to request changes to your demographic or practice information.

Please return the completed form to:

SUFFOLK HEALTH PLAN
521 FIFTH AVENUE, 3RD FLOOR
NEW YORK, NY 10175
PROVIDER RELATIONS DEPARTMENT
FAX NUMBER: 212-808-4772

Provider Name: _____ Current Provider/Practice TIN: _____

Practice Name: _____ NHP Provider Number _____
(If different)

Name of Office Contact: _____

Telephone No. of Office Contact: _____

Please make the following changes to your demographic/practice information:

ρ The New TIN number is _____

ρ We have moved! Our new address is effective _____

New: _____ Old: _____

Telephone _____

ρ We have changed our billing address. The new address is effective _____

New: _____ Old: _____

Telephone _____

ρ We have added the following physicians to our practice effective _____
Please send us contract/ Provider Application Form.

ρ The following physicians/providers have left our practice effective _____

ρ We are closing our practice to new patients effective _____

ρ We are reopening our practice to new patients effective _____

Signature of Participating Physician/ Provider