



Provider Information Request

Please circle one: CHANGE ADD DELETE

Name Last, First, MI	Type (MD, etc)	Specialty	NPI	Taxonomy	Medicaid#

For Peachstate Health Plan or Wellcare, is provider: PCP or SPC; Ages seen _____
 Accepting New Patients Y or N
 Is the physical address for the new info also your mailing address? Y or N
 Print in Directory Y or N

Note: If this change is for more than 3 providers, please attach a list of providers for which this change is applicable, as well as the required information.

Effective Date: _____

Old Information:

New Information:

Practice Name	Practice Name
Physical Address	Physical Address
City, State, Zip	City, State, Zip
Phone #:	Phone #:
Fax #:	Fax #:
TIN:	TIN:
Practice Manager:	Practice Manager
Billing Name	Billing Name
Billing Address	Billing Address
City, State, Zip	City, State, Zip
Phone #:	Phone #:
Fax #:	Fax #:
TIN:	TIN:
Billing contact:	Billing contact:

Please include a signed W-9 Form if this is a change of address or Tax ID.

Form completed by _____ Date _____

RETURN VIA FAX TO 229-312-8068