



# Hennepin Health

## PROVIDER DEMOGRAPHIC CHANGE FORM

Please complete this form when changing an address, phone number or office hours. If the information being changed pertains to more than one location, please complete a separate form for each location. Please include all clinic NPI numbers that the change applies to. If changing the Tax ID or billing address, a new W-9 will need to be completed. Please fax this form to (612) 632-8830.

Tax ID \_\_\_\_\_ NPI/UMPI \_\_\_\_\_ Effective Date of Change \_\_\_\_\_

### OLD Information:

Legal Name: \_\_\_\_\_

Doing Business As (DBA): \_\_\_\_\_

Website: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Physical Address Mailing Address Billing address

Address: \_\_\_\_\_ Address: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

### NEW Information:

Legal Name: \_\_\_\_\_

Doing Business As (DBA): \_\_\_\_\_

Website: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Physical Address Mailing Address Billing address

Address: \_\_\_\_\_ Address: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Hours of Operation: \_\_\_\_\_ Do you have Walk-in/Urgent Care hours? Yes  No  After-Hours Phone # \_\_\_\_\_  
(e.g. 9am – 5pm)

If Yes:

Monday _____	Monday _____
Tuesday _____	Tuesday _____
Wednesday _____	Wednesday _____
Thursday _____	Thursday _____
Friday _____	Friday _____
Saturday _____	Saturday _____
Sunday _____	Sunday _____

Publish Location in Directory? Yes  No

Person Completing Form (Print Name): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Email \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_