

# PROVIDER UPDATE FORM

Use this form to tell us about any new information or changes to your current practice or payment structure. You can email this completed form to [Provider.RelationsWest@premera.com](mailto:Provider.RelationsWest@premera.com) or fax it to 425-918-4937. If you have any questions, call Provider Relations at 800-722-4714, option 4.

Fields marked with an asterisk \* are required for all changes/updates.

**\*PROVIDER INFORMATION:**

\*Contact name: \_\_\_\_\_  
\*Phone: \_\_\_\_\_  
\*Email: \_\_\_\_\_  
\*Tax ID: \_\_\_\_\_

**\*Type of change/update:**

Address (any type)     New provider/clinic name     Phone (any type)     Add new location     Specialty     Tax ID (W-9 required)

\*Effective date of change: \_\_\_\_\_

**OLD INFORMATION:** Only complete the fields below where the current information we have on file is changing.

**Old clinic name:** \_\_\_\_\_

**Old provider name:** \_\_\_\_\_

**NPI:** \_\_\_\_\_

**Physical location address:**

Street address : \_\_\_\_\_

Suite number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**Phone number:** \_\_\_\_\_ **Fax number:** \_\_\_\_\_

**Specialty:** \_\_\_\_\_

**Remit/payable to address:**

Street address: \_\_\_\_\_

Suite number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**Mailing address:**

Street address: \_\_\_\_\_

Suite number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**Credentialing address:**

Street address: \_\_\_\_\_

Suite number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**Phone number:** \_\_\_\_\_ **Fax number:** \_\_\_\_\_

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**NEW INFORMATION:** Complete the fields below with your updated information.

**New clinic name:** \_\_\_\_\_

**New provider name:** \_\_\_\_\_

**Tax ID:** \_\_\_\_\_

**NPI:** \_\_\_\_\_

**New demographics apply to the following types of addresses: (check each one that applies).**

Physical Address     Mailing     Remit/Payable     Credentialing

Street address: \_\_\_\_\_

Suite number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**Phone number:** \_\_\_\_\_ **Fax number:** \_\_\_\_\_

**Specialty:** \_\_\_\_\_

**Other address (please explain in comments):**

Street address: \_\_\_\_\_

Suite number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**Phone number:** \_\_\_\_\_ **Fax number:** \_\_\_\_\_

**Comments:** \_\_\_\_\_

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