ProviderConnect Contact Information Change Form

Provider, Practice or Facility Name

ProviderConnect User ID

National Provider Identifier (NPI)

Provider, Practice or Facility Tax ID (do not include the dash)

Address

City

State

Zip Code

(_____)
Telephone Number

(_____)
Fax Number

Email address to be removed

New email address to be added

Contact Name (ProviderConnect Account User)

Agreement Terms:

The undersigned authorizes Carelon Health Options E-Support Services to change the contact information and email address associated with this account.

This is to certify that the following is true:

○ I am a provider

OR

○ I am office staff of a Provider, and am authorized to sign on their behalf.

Signatures:

Legal name of Organization

Title of individual signing for organization

Name of Individual Signing for Organization

Authorizing Signature

Date

Please return this form via fax to 866.698.6032

Carelon Health Options, Inc. | EDI Helpdesk | PO Box 1287, Latham, NY 12110 | Phone#: 888.247.9311

Incomplete, incorrect or illegible forms may delay or prevent proper processing