

Demographic Change Form

If you need to advise us of demographic changes made at your practice, please complete and email this form to database@hcpipa.com or fax to (516) 746-8473. To deactivate a location or list additional offices or covering locations, please attach additional documentation on practice letterhead.

Provider Information		
HCP ID #:	TIN #:	Provider NPI #:
Provider Name:	Vendor/Group NPI #:	
Provider Email:	EMR Type:	EMR Version:
Primary Contact Name:	Phone #:	Email:

Service Information (Important: Please indicate office order. List extended office hours, if applicable.)

	Primary Office			Secondary Office		
Group Name						
Street / Suite #						
City, State, Zip						
Phone #						
Fax #						
Office Hours *Specify hours during which the provider is seeing patients	Mon	Tue	Wed	Mon	Tue	Wed
	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____
	Thu	Fri	Sat	Thu	Fri	Sat
	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____
Extended Office Hours						
	Same/next day appt. availability? Y ___/N ___			Same/next day appt. availability? Y ___/N ___		
	Handicap Accessible? Y ___/N ___			Handicap Accessible? Y ___/N ___		
	Additional Office 1			Additional Office 2		
Group Name						
Street / Suite #						
City, State, Zip						
Phone #						
Fax #						
Office Hours *Specify hours during which the provider is seeing patients	Mon	Tue	Wed	Mon	Tue	Wed
	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____
	Thu	Fri	Sat	Thu	Fri	Sat
	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____
Extended Office Hours						
	Same/next day appt. availability? Y ___/N ___			Same/next day appt. availability? Y ___/N ___		
	Handicap Accessible? Y ___/N ___			Handicap Accessible? Y ___/N ___		

Please include phone, fax numbers and office hours for each location.

W-9 (One billing address per TIN #)

	Primary Billing Address	Secondary Billing Address
Group Name		
Street / Suite #		
City, State, Zip		
Phone #		
Fax #		
Tax ID		

