# PROVIDER UPDATE FORM

***UPDATES ARE PROCESSED ACCORDING TO THE DATE RECEIVED***

| TYPE OF UPDATE | | | | | |
|---|---|---|---|---|---|
| NEW HIRE | ◯ | UPDATE PROVIDER INFORMATION | ◯ | TERMINATION | ◯ |
| EFFECTIVE DATE | | | | | |

| PROVIDER DEMOGRAPHICS | | | | | |
|---|---|---|---|---|---|
| FIRST NAME | | MIDDLE | | LAST | |
| PROFESSIONAL DESIGNATION (AUD, AuD, HAD, HIS, HAS) | | | | GENDER | |
| PRIMARY WORK EMAIL ADDRESS | | | | | |
| PRIMARY WORK PHONE NUMBER | | | DATE OF BIRTH | | |
| LICENSE NUMBER(S) AND STATE | | | TYPE 1 NPI | | |
| MEDICARE PTAN | | MEDICAID # | | CAQH ID | |

| BUSINESS DEMOGRAPHICS (REQUIRED) | |
|---|---|
| EIN/TAX IDENTIFICATION NUMBER | |
| LEGAL BUSINESS NAME | |

| PROVIDER'S PRIMARY PRACTICE LOCATION | |
|---|---|
| STREET ADDRESS | |
| CITY, STATE AND ZIP CODE | |
| **ADDITIONAL PRACTICE LOCATION** | |
| STREET ADDRESS | |
| CITY, STATE AND ZIP CODE | |
| **ADDITIONAL PRACTICE LOCATION** | |
| STREET ADDRESS | |
| CITY, STATE AND ZIP CODE | |
| **ADDITIONAL PRACTICE LOCATION** | |
| STREET ADDRESS | |
| CITY, STATE AND ZIP CODE | |
| **FOR ADDITIONAL LOCATIONS, PLEASE ATTACH A ROSTER** | |

Submitted By: _____Date: _____

Email Address: _____Phone Number: _____

***THIS FORM MUST BE SUBMITTED BY AN OWNER OR AUTHORIZED CONTACT***

**How to submit the Provider Update Form:**

Preferred Method: E-mail form to Credentialing@amplifon.com
Fax: (877) 853-3010 Phone: 1-800-862-9381

**Please Note:** The name listed on the Update Form should be consistent with what is listed on the provider's practice license.

After submitting a Provider Update Form to Amplifon Hearing Health Care, you should expect system changes to take effect in 10-14 business days after receipt. However, to ensure that a change request for a site addition or termination is completed by the requested effective date, the Provider Update Form should be submitted to Amplifon Hearing Health Care 30 days in advance of the requested effective date.

***For location changes, please complete a Location Update Form***