PEOPLES HEALTH

PROVIDER INFORMATION CHANGE FORM (PICF)

Please **Type or Print** and fax PICF to the Provider Relations Department
Fax (504) 849-6916
Note: Limit Provider changes to one per form (this is also applicable to office locations)

Section 1 – To be filled out by Provider Office

Attachments: ☐ **YES** ☐ **NO**

Effective Date of Change:

Please check ALL applicable Physician Team(s):

☐ **CPT** ☐ **HPT** ☐ **MPT** ☐ **NLPT** ☐ **NPT** ☐ **PPT** ☐ **OW** ☐ **OS** ☐ **SD**

☐ **PAPT** ☐ **SLPT** ☐ **SPT** ☐ **TLPT** ☐ **UPT** ☐ **ON** ☐ **OB**

☐ **Hospital/Ancillary**

Specialty(ies):

Section 2 – To be filled out by Provider Office

Provider's Name(s) and Title:

Group Name: Office Hours:

Street Address: Suite No.

City: State: Zip:

Phone Number: Referral Fax Number:

Contact Person: Contact Person's Phone Number:

Correspondence Fax Number (s)

Comments:

Section 3 – To be filled out by Provider Office

Please check ALL applicable change(s):

☐ Office(s) Address (**Temp or Perm**) ☐ Billing Address ☐ Additional Office Location (**Temp or Perm**)

☐ Tax ID Number * ☐ Telephone Number ☐ Correspondence Address

☐ Referral Fax ☐ Primary Address ☐ Correspondence Fax

Other (please provide details):

*** W-9 Form must be attached in order to change Tax ID Number(s)**

Section 4 – For Peoples Health Internal Use Only

Date Submitted: Submitted By: Department:

Effective Date of Change: Provider Number: Office Number:

Date Received in Data Entry: Date Entered into AMISYS by Credentialing:

Contract Administration Use:

Date verified: Date of verification of system changes:

MAIL TO: Peoples Health - Three Lakeway Center - 3838 N Causeway Boulevard - Suite 2200 - Metairie, LA 70002