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EBPA BENEFITS PROVIDER UPDATE REQUEST

Type of Change Requested
(Check All That Apply)

☐ TIN Change ☐ Address Change ☐ Add Provider ☐ Term Provider

TIN _____ New TIN _____

Effective Date _____ Term Date _____

Provider Name _____

NPI _____

Practice Name _____

NPI _____

Street Address _____

City _____ State _____ ZIP _____

Phone Number _____ Fax Number _____

PAYMENT REMIT ADDRESS INFORMATION

Street Address/PO Box _____

City _____ State _____ ZIP _____

Phone Number _____ Fax Number _____

email for us to contact you with confirmation: _____