



PARTNERSHIP HEALTHPLAN OF CALIFORNIA
PROVIDER CHANGE FORM

In order for Partnership to keep our records updated, we need your help.
Please check the appropriate box and indicate at the bottom of the form the effective date of the change(s) made.
Fax this form with your changes to the Provider Relations Dept. at 707-207-0436.

Current Physician or Practice Name: _____

New Name: _____

Telephone Number Change: _____

Fax Number Change: _____

Change of Location or Additional Practice Site:

Address: _____

Did you send Members a letter? Yes / No

Please include a copy of the letter with the Provider Change Form

Billing Service Change:

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Contact Person: _____

Change Pay to address as indicated above: Yes / No

Change Cap Check (PCP's only) Pay to address as indicated above: Yes / No

CHANGE OF:

Tax I.D.#: _____ Group Name: _____

SSN #: _____ Physician Name: _____

Office Manager Change: _____

Name of New Physician and Specialty: _____

Name of Physician Leaving Practice: _____

Did you send Members a letter? Yes / No

Please include a copy of the letter with the Provider Change Form

Other: _____

Date Change(s) Became Effective: _____

Name of office staff completing form: _____

Signature: _____ Phone # _____ Date: _____