CenterLight®
Healthcare

Program of All-Inclusive Care for the Elderly (PACE)

Provider Demographic Change Request Form

Submit completed form to CenterLight Healthcare: **providerrelationsrequest@centerlight.org**

CURRENT PROVIDER INFORMATION

Provider/Organization Name: _____ Tax ID: _____

Specialty: _____ NPI: _____

Medicare #: _____ Medicaid: _____

Member DOB: _____ Physician Address: _____

INDIVIDUAL PROVIDER GROUP PRACTICE INSTITUTION/FACILITY

Date change will take effect: _____

Type of Change: (Please check all that apply)

☐ Add TIN	☐ Change Billing Address	☐ Change Name (Group or Physician)
☐ Deactivate TIN	☐ Add Service Address	☐ Change or Add Hospital Affiliation
☐ Change TIN	☐ Delete Service Address	☐ Change Speciality: _____

NEW DEMOGRAPHIC INFORMATION

New Service Information: (If more than one location, attach additional sheet)

Tax ID: _____

Individual Name: _____ Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

Tax ID: _____ NPI: _____

CenterLight TeamCare - Provider Services
136-65 37th Ave., Flushing, NY 11354
1-800-761-5602 Phone | 315-750-3380 Fax | 9am - 5pm Monday - Friday

NEW BILLING/REMITTANCE INFORMATION: (W-9 FORM MUST BE SUBMITTED WITH ALL TAX ID UPDATES)

Pay to Indicator: Individual / Group _____

☐ Billing ☐ Remittance **(select one)**

Name: _____ (As shown on your income tax return)

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

Tax ID: _____ Billing NPI: _____

(For explanation of new billing and remittance please attach a separate sheet on company letter head)

OLD DEMOGRAPHIC INFORMATION

Old Service Information: (If more than one location, attach additional sheet)

Primary Service Location? ☐ Yes ☐ No

Individual Name: _____

Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

Tax ID: _____ NPI: _____

Old Billing/Remittance Information: (W-9 form must be submitted with all TAX ID updates)

Pay to Indicator: Individual / Group_____

☐ Billing ☐ Remittance **(select one)**

Name: _____(As shown on your income tax return)

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

Tax ID: _____ Billing NPI: _____

(For explanation of new billing and remittance please attach a separate sheet on company letter head)

Authorized signature: _____

Telephone number: _____ **Email:**_____