Scott & White Health Plan - Provider Data Update Notification

Provider Data Update Form

* Indicates a required field

*Name of Provider/Group:

Phone Number:

Fax Number:

*NPI Number: Group __ Individual __

Tax ID Number:

Please Select All That Apply:

__ Name Change

__ Billing Address / Telephone Change

__ Tax ID Number Change

__ Office Address / Telephone Change

__ Adding Location

__ Other Change (*Explain Below*)

*Effective Date of Change __ __ ____ i.e. 01 07 2008

Please specify if the information you are providing is a change to existing information on file or if it is new additional information.

___ New Information
___ Changed Information

Name of Submitter:
Title: Phone:

*If your preferred method is to print and fax, please specify the changes or new information you will be making in the **"Please Select All That Apply"** section.*

Fax: (254) 298-3044
Submit Print