

**SCOTT & WHITE HEALTH PLAN
PROVIDER ADDRESS/PHONE CHANGE FORM**

National Provider ID#: _____

Organization Name: _____

First Name: _____ **Last Name:** _____

NEW Street Address: _____

City: _____ **State:** _____ **Zip:** _____

NEW Phone: (____) _____ **NEW Fax:** (____) _____

PLEASE COMPLETE FORM AND FAX TO SWHP PROVIDER RELATIONS, FAX# (254) 298-3044. IF YOU HAVE FURTHER QUESTIONS, PLEASE CONTACT US AT 1-800-321-7947.