NETWORK CHANGE FORM

Employees Group Insurance Division

NAME OF PRACTITIONER (attach roster if needed)

Last, First Middle initial	License type

NAME OF INDEPENDENT HEALTH ORGANIZATION OR FACILITY

IHO or facility name

GENERAL INFORMATION

Primary specialty	Secondary specialty
Tax ID number (attach W-9 form)	Medicare number (if applicable)
NPI type I (individual)	NPI type II (organization)
Practice email (for publication)	Website (for publication)

PREVIOUS PHYSICAL ADDRESS	NEW PHYSICAL ADDRESS
Practice name	Practice name
Legal name	Legal name
Street address City State ZIP code	Street address City State ZIP code
Phone	Phone

PREVIOUS CONTACT INFORMATION	NEW OFFICE CONTACT INFORMATION
Contact name	Contact name
Phone	Phone
Email	Email

Contact information will be utilized for all legal and contractual notices as defined in sections 12.2 of the Practitioner contract and 11.1 of the IHO and Facility contracts. A contact email address must be included. All notices will be sent electronically.

SIGNATURE AND DATE

Authorized signature	Effective date

RETURN TO EGID BY EMAIL

Email: EGID.NetworkManagement@ohca.ok.gov

Attach a completed W-9 form for each TIN, Medicare certification and/or accreditation, if applicable.