PROVIDER DEMOGRAPHIC CHANGE

Please use one page per change. Fill in all fields. Indicate the change type for this page:

	Add	Term	Change
Address:	☐	☐	☐
Tax ID:	☐	☐	☐
Other:	_____		☐

Submit to Ohio Health Choice using one of these methods:

Fax: 330-996-8211
Email: OHCProviderRelations@OhioHealthChoice.com
Address: Ohio Health Choice
Attn: Provider Relations
PO Box 2090
Akron, OH 44309-2090

Eff Date: _____ Tax ID #: _____ Individual NPI: _____

Provider Name: _____

OLD information (leave blank for Adds):

_____

_____

_____

_____

NEW information (leave blank for Terms):
(Note: addresses require phone number)

_____

_____

_____

_____

Requestor Name:_____

Requestor Email: _____ Phone: _____