MDX Hawai'i

Demographic Update Form – Individual (Rev. 01/2024)

To update information on an existing provider record, please complete and return this form and supporting documents via: EMAIL: MDXHawaii@coniferhealth.com
FAX: 818-817-5178

PROVIDER NAME: _____ TIN: _____

Please check the appropriate change type and complete appropriate fields. **NPI:** _____

☐ **NAME CHANGE**
New Name_____ Effective Date:_____

☐ **ADDRESS NEW (Please attach a copy of your W-9)**
Applies to: ☐ Pay-To/Billing Address ☐ Practice Address Effective Date:_____
Street/PO Box:_____Phone:_____
City, State: _____Fax: _____
Zip Code: _____ Email: _____
Hours of Operation: _____
Is location accessible to persons with disabilities? ☐ Yes ☐ No

☐ **ADDRESS TERMINATION**
Applies to: ☐ Pay-To/Billing Address ☐ Practice Address Effective Date:_____
Street/PO Box:_____Phone:_____
City, State: _____Fax: _____
Zip Code: _____ Email: _____

☐ **TIN CHANGE (Please attach a copy of your W 9 for new TIN)**
New TIN:_____ Effective Date:_____
Terminate TIN:_____ Effective Date:_____

☐ **CONTACT INFORMATION NEW (Please attach a copy of your W-9)**
Applies to: ☐ Pay-To/Billing Address ☐ Practice Address Effective Date:_____
Email: _____ Phone:_____Fax: _____

☐ **CONTACT INFORMATION TERMINATE**
Applies to: ☐ Pay-To/Billing Address ☐ Practice Address Effective Date:_____
Email: _____ Phone:_____Fax: _____

☐ **PRACTICE PANEL** Effective Date: _____
Accepting New Patients ☐ Commercial ☐ Humana HMO ☐ Humana PPO ☐ UHC PPO
Closed Panel-Existing Patients Only ☐ Commercial ☐ Humana HMO ☐ Humana PPO ☐ UHC PPO

☐ **CAQH #** _____

_____

REQUIRED SUBMITTER INFORMATION

Name of person completing this form: _____ Date: _____
Email: _____ Phone:_____