Cornerstone ALLIANCE, INC

Practitioner Office Information Change Form

Complete the boxes below

Email to cornerstonealliance@wcoil.com or Fax to (419) 229-2273

BOX 1

- ❑ Adding new location(s)
- ❑ Deleting a location
- ❑ Relocating and Changing all addresses (must include copy of W-9)
- ❑ Adding New Tax ID# (must include copy of W-9)
- ❑ Change Tax ID# (must include copy of W-9)
- ❑ Practitioner Terminating from group or Cornerstone Alliance
- ❑ Change Remit (billing) address only (must include copy of W-9)

BOX 2 **Previous Information or Information Being Deleted**

Practice Name (dba): _____

Name of Practitioner(s): _____

Address: _____ Tax ID # _____

_____

BOX 3 **New Information (*Attach separate sheet for additional addresses)**

Practice Name (dba): _____ Effective Date: _____

Name on W-9 (legal name): _____ Tax ID #: _____NPI#_____

Please include copy of W9

Office Location: _____ Phone: _____

Street *Ste./Bldg./etc.*

_____ Fax: _____

City/State/Zip

Office Contact Person: _____ E-mail address_____

Billing Address if different from office location: _____ Phone: _____

Street *Ste./Bldg./etc.*

_____ Fax: _____

City/State/Zip

Billing Contact Person: _____

BOX 4 **Termination Information**

Name of Practitioner(s) leaving the practice: _____

Effective Date of Termination: _____ Physician's Forwarding Phone Number: _____

BOX 5 – MUST BE COMPLETED **Termination Reason**

Reason for departure _____

Name of Practitioner you are requesting Medicaid Managed Care Members be assigned to _____

BOX 6

Form Completed By: _____ Phone: _____ Date _____

Credentialing Contact Person: _____ Phone: _____