

PROVIDER UPDATE FORM

It is very important that our files remain up to date and current. Please notify us of your address, phone number, and Tax ID number or Social Security number within 30 days. You may mail this form to address noted below or fax to your provider relations representative.

Please check which Medicaid Plan this affects:

- Kansas HealthWave** **MO HealthNet**

Effective Date: / /

Physical Location	Practice Name:
	Street:
	City, State Zip
	Phone#: Fax#:

Mail Address	Street:
	City, State Zip
	Phone#: Fax#:

Payment Address	Street:
	City, State Zip
	Phone#: Fax#:

Email Address:

NPI	NATIONAL PROVIDER IDENTIFIER INFORMATION
	NPI #:
	Taxonomy Code:

REQUIRED INFORMATION:		
CMFHP ID #:	TAX ID#:	
Contact Name:	Phone Number:	
Authorized Signature:	Date:	

This form may be faxed to 816-471-1832 or mailed to:

*Childrens Mercy Family Health Partners
 ATTN: Provider Relations
 PO Box 411806
 Kansas City, MO 64141-1806.*

If you have any questions, please contact your Provider Relations Representative.