CHORUS COMMUNITY HEALTH PLANS

Provider Update / Change Form

This form should be used when changing a practitioner, location, phone or fax number, billing or email address, and office hours. Please email or mail to CCHP.

Email to cchp-providerupdates@chw.org
Mail to: CCHP Provider Relations
P.O. Box 1997, MS 6280
Milwaukee, WI 53201-1997

Changes in a tax ID number or Group name requires you to submit a W-9 form or IRS letter (SS4 or 147C). Please email those changes to: cchp-contracting@chw.org. (File size may not exceed 4 MB when being emailed. File types accepted include: .doc; .docx; .rtf; .xls; .pdf)/

Effective date of change:

Type of update:

Group ○
Practitioner ○

Type of changes:

○ Practitioner's Name
○ Add Practice Location
○ Term Practice Location
○ Billing
○ Other

SECTION 1: Old Information

(Note: Changes for practitioners and / or providers through a group must be submitted by the group.)

Name of Practitioner / Group (Include Legal Name Doing Business as):			
Federal Tax ID Number:	Group NPI:	Individual NPI:	
PRACTICE LOCATION			
Street Address:	City:	State:	Zip:
Phone Number:	Fax Number:		
BILLING ADDRESS			
Street Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Internal Reference: COR Form – Update Change Form (2022.0831)

CHORUS
COMMUNITY HEALTH PLANS

SECTION 2: New Information

PRACTICE LOCATION			
Street Address:	City:	State:	Zip:
Phone Number:	Fax Number:		
BILLING ADDRESS			
Street Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

SECTION 3: Hours of Operation

List all days and hours your practice is open. (Example: M 8AM – 5PM ; W 9AM-5PM)

SECTION 4: Person Completing Form

Name of Orgnization You Represent:	Title:		
Street Address:	City:	State:	Zip:
Phone Number:	Email Address:		

SECTION 5: Roster of Practitioners / Providers Practing with Group (Attach Separate Roster Sheet)

Comments: