

HNS

Notification of Type 2 Practice Changes

HNS is responsible for ensuring our database includes accurate information regarding your practice, and for promptly notifying all contracted healthcare plans with any changes regarding your practice.

Type 2 changes are those practice changes which require the submission of an updated W-9 form, and include:

- Change to legal name of practice
- Change to DBA of practice
- Change to provider's name
- Changes regarding your Type 2 NPI number
- Change of practice address
- Change to Tax ID / EIN

Instructions:

1. On page 2, please circle or underline each change that applies.
2. Please print or type clearly.
3. Please complete both Sections A and B of the form.
4. *Please do not leave any lines blank.* All requested information must be provided.
5. **W-9 Form Required:** You must provide a newly completed W-9 form when submitting this form to HNS.
6. The form must be signed by the provider as his/her attestation of the accuracy of the information on the form.
7. Please email or fax the completed form to HNS together with a new W-9.
(Fax number: (877) 329-2620)
8. ***Please do NOT notify payors of any changes to your practice.*** HNS will notify all contracted healthcare plans of these changes. (While payors will promptly update their database with these changes, it may take 4-6 weeks for their provider directories to reflect the changes.)

HNS Notification of Type 2 Practice Changes

(W-9 Required)

Date: _____ Effective date of change: _____

Type 2 Changes: **Please circle or underline each change that applies:**

- Change to legal name of practice
- Change to DBA of practice
- Change to provider's name
- Changes regarding your Type 2 NPI number
- Change of practice address
- Change to Tax ID / EIN

(Please Note: Electronic payments (EFT) from HNS are linked to your EIN. If you have changed your EIN, you must update your EFT information on the secure portion of the HNS website with your new EIN to ensure HNS payments are deposited into the appropriate bank account.

Section A - Previous Information:

Please provide the following regarding your previous practice information and **complete all blanks.**

Provider Name: _____
(Last) (First) (M)

Legal name of practice: _____

DBA: _____

Provider Type I NPI: _____ Provider Type II NPI: _____

TAX ID/EIN: _____ Practice Software: _____

Practice Information

Practice Physical Address:

_____ County: _____
Office phone number: _____
Office fax number: _____
Office contact: _____

List ALL Providers practicing at this location

Name of provider	Type 1 NPI	Tax ID (EIN)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Section B - New Information

1. Are you leaving an existing practice and joining another practice already part of the HNS Network? **(Please indicate either YES or NO.)**
2. Are you leaving an existing practice and opening his own practice? **(Please indicate either YES or NO.)**

If you are a NC provider, and answered YES to either of the above questions, you must attach evidence you have submitted a Participation Agreement to HIEA (HealthConnex). Acceptable evidence is an **executed** copy of the agreement OR an email from HIEA which indicates HIEA has received your Participation Agreement.

Please provide the following regarding your NEW practice information, and please complete all blanks

Provider Name: _____
(Last) (First) (M)

Legal name of practice: _____

DBA: _____

Provider Type I NPI: _____ Provider Type II NPI: _____

TAX ID/EIN: _____ Provider's Software: _____

Please Note: EFTs from HNS are linked to your EIN. If you have changed your EIN, you must update your EFT registration on the secure portion of the HNS website.

Practice Information

Practice Physical Address: _____ County: _____

Office phone number: _____

Office fax number: _____

Office contact: _____

Office Hours:

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Name of provider	Type 1 NPI	Tax ID (EIN)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of Provider

Please email or fax pages 2, 3 of this form with a completed W-9, and, as applicable, evidence of participation with HealthConnex. Fax:(877) 329-2620.