HANA HOU
MEDICAL GROUP

Provider Information Update Form

Instructions: Fill out all relevant details. Incomplete submissions may be returned without processing. This form is not intended for new providers or contractual/credentialing modifications. Please submit form to provider to Hana Hou Medical Group Provider Relations Department via email info@hanahoumedicalgroup.com or fax (888) 847 - 8215. Note: Please allow 7 – 10 Business days for your change to be processed.

Provider Name: _____ **Effective Date of Change:**_____

Indicate Change : □ Practice Information □ Billing Information □ Termination

Section 1: Office Address Update *(Enter New or additional Address, please submit W9 if billing there is a new billing address update)*

Address Type □ Primary □ Secondary □ Billing □ Mailing Address

Adding or Update Address:

Address: _____

City: _____State: _____Zip: _____

Phone: _____Fax: _____Email Address: _____

Office Hours: _____Staff Language: _____

Panel Status: □ Open □ Close □ Accepting existing patients only □ Concierge Practice

Remove Office Address:

Address: _____

City: _____State: _____Zip: _____

Section 2: Termination *(Effective date may be impacted by contract terms and follow up may be required)*

□ Resigned □ Retired □ Practice closed □ Leave of absence* □ Sabbatical*

* Please provide a separate explanation of the details (i.e., duration of absence for leave/sabbatical)

Section 3: Contact Person - Submitting Information

Name: _____Email Address: _____

Physician Signature: _____ Date of submission: _____