



Provider Update Form

Please note this is not a credentialing application. If credentialing is required for a practitioner, a My Choice Wisconsin staff member will reach out to begin the credentialing process.

Organizational Information

Contracted Entity Name	
Form Submitted by – Name & Title	
Email Address	Taxpayer ID (TIN, FEIN)
Phone Number	Fax Number

Reason for Update: Please provide additional information in specified sections.

- Contact Information Change (Section 1)
- Practitioner Change (Section 2)
- Tax ID Change (Section 1)
- Service Location Change (Section 3)
- Legal Name Change (Section 1)

UPDATED ORGANIZATIONAL INFORMATION (Section 1)

Complete only applicable fields that require change.*Please attach a current W9 for Tax ID change and billing address.

Effective date for below changes:

New Legal Name as indicated on W9	New Taxpayer ID (TIN, FEIN)
New Billing Address (Include City, State & Zip Code)	County
New Mailing Address (Include City, State & Zip Code)	County

Contact Type: Billing-Credentialing-Corporate-Contracting	
New Phone Number	New Fax Number
New Contact Name	New Contact Title
New Contact Phone Number	New Contact Fax Number
New Contact Email Address	



Confidential

10201 W Innovation Drive
 Wauwatosa WI 53226
 (800) 963-0035
 Fax: (608) 245-3844
www.mychoicewi.org

UPDATED PRACTITIONER INFORMATION (Section 2)

*If adding a new practitioner, please complete the 'Additional Practitioner Form.'

Last Name	First Name	Middle Name
NPI	Primary Specialty	Additional Specialty
Degree	Accepting New Patients? Y/N	Primary Care Provider? Y/N

Reason for update: Select all that apply

- Practitioner Leaving Location
- Practitioner Changing Location
- Practitioner Leaving Practice
- Practitioner Death
- Practitioner Retirement
- Name Change
- Other:

Effective Date:

Old Location:

New Location:

New Practitioner Name:

SERVICE LOCATION CHANGE (Section 3)

To update information regarding your service location, or a location move please complete the below.

*To add a brand new location to our network, please complete the 'Additional Location Form.'

Effective date for below changes:

Old Location Name		Old Taxpayer ID (TIN, FEIN)
Old Address (Include City, State & Zip Code)		County
Old Phone Number	Old Fax Number	Old NPI
Old Contact Name & Title		Old Contact Email Address

New Location Name		New Taxpayer ID (TIN, FEIN)
New Address (Include City, State & Zip Code)		County
New Phone Number	New Fax Number	New NPI
New Contact Name & Title		New Contact Email Address
Print in Directory? Y/N	Handicap Accessible? Y/N	
Medical Records Fax Number		

Please return your completed form to our Provider Services Department:

By Fax: 608-245-3844 – Attn: PS Provider Updates

By Email: [pscscs@carewisc.org](mailto:pscs@carewisc.org) – Subject: Provider Update Form

Questions? Please contact our Provider Services Department at 1-800-963-0035