Request for a new provider ☐ **Change to an existing provider** ☐

Professional Provider:

First Name/Middle Initial:

Last name/Generation/Degree:

Taxonomy Code: NPI Number:

State License Number & Issue Date:

Ancillary or Facility Provider:

Provider Name: NPI Number:

State License Number & Issue Date: Taxonomy Code:

Demographic Information:

Primary Location ☐ Secondary Location ☐

Address:

Payments:

Make checks payable to:

☐ Payments should be made for individual provider

☐ Roll payments up to a single check for all providers in the group

Group Name if applicable:

Group/Organization NPI Number:

Pay to Address:

IRS (W-9) Name: TIN# or SSN# (for tax purposes):

IRS (W-9) Address:

Contact Name: Title: Phone:

Email:

Practitioner or Office Manager Signature: Date:

If you have any questions or needs assistance please call 1-844-874-8301
Please email the completed form(s) to providers@fbhealthplans.com or fax to 931-560-4278