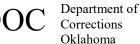
He-IthChoice (DRS

Oklahoma Department of Rehabilitation



Services

NETWORK CHANGE FORM

Last name, first name, MI (attach roster if necessary) or independent health or facility name License type (if applicable) Primary specialty Secondary specialty Federal TIN Medicare number (if applicable) NPI type II for IHO/facility NPI type I for practitioner **Old physical address** New physical address Practice name Practice name Street address Street address City, State, ZIP code City, State, ZIP code Phone Phone Fax Fax Old mailing address New mailing address Mailing name Mailing name Mailing address Mailing address City, State, ZIP code City, State, ZIP code Phone Phone Contact Fax Email address Contact Email address Tax ID number (Attach a completed W-9 Form) TIN Authorized signature Mailing contact information will be utilized for all payments, legal and NPI (Type I for provider, Type II for group/facility) contractual notices as defined in section 12.2 of the provider contract and 11.1 of the facility contracts, as well as, payment related notices/documents. An email address must be included. All notices will be sent electronically. Effective date