Teachers Health Trust

CHANGE IN NAME OR TAX ID FORM

(Please Print)

Date: ______/_______/_________

OLD INFORMATION

Name of Group:	❑ **Group Name Change** ❑ **Tax ID Dissolved** ❑ **Change in Ownership**	❑ **Address Change** ❑ **Tax ID** (not dissolved) Requesting to contract a **new** Tax ID.
Tax ID #:		
Changes are Effective: ______/______/_______		

NEW INFORMATION

New Group Name:		**New** Tax ID:	
Mailing /Remittance Address:			
Mailing Address2:			
City:	Zip Code:		
Is Physical Address Different?	❑ Yes	❑ No	If yes, please list physical address below.
Physical Address:		City:	Zip Code:

PROVIDERS - Please list all providers who will be billing under the new Name, or Tax ID

Provider Name	**Title**	**Specialty**

Please Note: Return a **W9**, or an **EIN 147C** form with this Change Form to avoid a delay in processing. Please complete the information below, (authorized signature is required), and fax completed form to Teachers Health Trust (702) 866-6121.

CONTACT INFORMATION

(Please Print)

Contact Name of Person Completing Form:	E-mail Address:	Phone Number:	Fax Number:
		( )	( )

*Authorized Signature **(Required):*** ____

Authorized Signature Name (Please Print): ___________________________________ *Date:* _________/_________/_________