

Change of Information Form

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1. Complete the Provider Demographic Update form with all current information. 2. Email the form by clicking the Submit by Email button or Fax to: 713 500-3330 3. If you are changing Billing Information (Tax ID or Address) you will need to include a W-9 with this form. **CURRENT INFORMATION** Provider/Group Name: Email Address: What type of change are you requesting? Address Availability Other **ADDRESS CHANGES Practice Address:** New Address Update: Suite/Fax/Tel/Email Effective Date: Street: Suite: County: City: Zip: State: Office ph: Office Fax: Message ph/cell: **OFFICE HOURS AT THIS LOCATION** Mon: Tue: Wed: Thu: Fri: Sat: Sun: **ADDITIONAL LOCATION** 2nd Address: New Address Update: Suite/Fax/Tel/Email Effective Date: Street: Suite: State: Zip: County: City: Message ph/cell: Office Fax: Office ph: **OFFICE HOURS AT THIS LOCATION** Tue: Wed: Thu: Mon: Fri: Sat: Sun: **DELETE LOCATION** Effective Date: Street: Suite: City: State: Zip: County: Office ph: Office Fax: Date Effective: **BILLING ADDRESS CHANGE - MUST SUBMIT A NEW W9 (WWW.IRS.GOV)** Billing Address: New Address Effective Date: Street: Suite: Zip: County: City: State: Office ph: Office Fax: Message ph/cell: **TERMINATE PARTICIPATION REQUEST** Effective Date of Termination: Reason for Termination: Are you currently seeing any UTEAP clients: Yes No (If Yes, please contact 1 800 346-3549 for continuation of care options) Do you have any outstanding invoices to submit to UTEAP?: Yes No (If Yes, please fax to 713 500-3330) Written Signature(Fax Only): Date: Electronic Signature(Email Only):

Date: