Humana
Behavioral Health

Provider/Group Demographic Update Form

_____ _____ _____
Date Provider/Group Name (Last, First, M.) & License Level TIN#

Are you moving to a new location? ☐ **Yes** ☐ **No** If yes, please indicate **NEW** location below

_____ _____ _____ _____
Primary Clinical Address City State ZIP Code

_____ _____ _____
Primary Phone Number Fax Number E-mail address

Are you adding a new location? ☐ **Yes** ☐ **No** If yes, please indicate **NEW** location below

_____ _____ _____ _____
Primary Clinical Address City State ZIP Code

_____ _____ _____
Primary Phone Number Fax Number E-mail address

Primary Billing Information ****W9 required for all billing address changes****

_____ _____ _____ _____
Primary Billing Address City State ZIP Code

_____ _____ _____ _____
Primary Mailing Address City State ZIP Code

Patient Ages ☐ 0 - 17 ☐ 18 & up ☐ other_____ **Accepting New Patients** ☐ Yes ☐ No

Additional Practice Affiliations

☐ Yes ☐ No If yes, please include the practice name & location _____

Groups only **Are there additional providers in your practice?** ☐ **Yes** ☐ **No**

If yes, please attach a group roster with the following information: Providers Name (Last, First, M.), License Level

- Provider's Name (Last, First, Middle initial) & License Level
- Location(s) at which they practice
- CAQH id (if available)

Upon completion, please fax to Provider Relations at 866-662-9683

Updates may take up to 30 days