



Annual Provider Update Form

Provider Name/Group Name:

Group Members (Please list with NPI):

Correspondence/ Mailing/ Remit address:

Servicing Location/Address:

List each additional servicing location:

Email:

Office Phone # (for insurance directories):

HAM Contact Phone #:

Tax Id:

Provider/Group NPI:

Last Four digits of the banking account:

In- Network Insurance Plans:

Out of Network Plans you may be submitting to:

Plans you are currently receiving direct deposit payments for: