VENTURA COUNTY
HEALTH CARE PLAN

# Provider Update Request Form

## Current Practice information

**Effective Date of Change:** _____ ☐ Group Practice ☐ Individual Provider

Name of Group/Individual Provider: _____

NPI #: _____ TAX ID #: _____

Practice Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____ Email: _____

## Provider Change Information

**Type of Change:**

☐ Address/Billing Change ☐ Telephone/Fax Number ☐ Email Address

☐ Closed/Open to New Members ☐ NPI Change ☐ Tax ID Change

☐ Adding a Location ☐ Adding a Provider ☐ Terming a Provider

**New Office Information:**

Name of Group/Individual Provider: _____

NPI #: _____ Tax ID #: _____

Practice Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____ Email: _____

**Providers – Please list providers that have been added or deleted from your practice.**

Last Name: _____ First: _____ Middle: _____ Degree: _____

NPI #: _____ License #: _____

Last Name: _____ First: _____ Middle: _____ Degree: _____

NPI #: _____ License #: _____

**Change of Ownership:**

Legal Business Name of New Owner: _____

Tax ID Number of New Owner (Requires W-9 Form): _____

**Authorized by:**

Name: _____ Title: _____

Signature: _____ Date: _____

Please email, mail, or fax this change form and supporting documentation to: Provider Services Department at VCHCP.ProviderServices@Ventura.org; 2220 E. Gonzales Rd. #210-B, Oxnard, CA. 93036; Fax: 805-981-5051.