Astrana Health
Provider Relations NorCal Department
Phone: (415) 216-0093
Fax: (888) 327-1168
Email: ProviderRelationsNorCal@AstranaHealth.com

Provider Demographic Change Form

Please fill out and return to our Provider Relations Department in order to update Provider's information below. Information must be requested in writing.

1. *What IPA does this change correspond to?* Please check all that apply:

☐ Access Primary Care Medical Group ☐ All American Medical Group ☐ Jade Health Care Medical Group

2. ***Provider Name:*** _____ ***Vendor Name:*** _____

Specialty: _____ ***Tax ID:*** _____

☐ Applies to all providers within this Vendor

3. *What's Changing?* Please check all that apply:

☐ Practice Location ☐ Billing Address ☐ Phone Number
☐ Fax Number ☐ Age Restriction ☐ Other Update

A W9 is required with billing address change

4.

	Practice Location ☐ Same as billing Address		Billing / Remit Address
Street:		***Street:***	
City:		***City:***	
State:		***State:***	
Zip Code:		***Zip Code:***	
Phone:		***Phone:***	
Fax:		***Fax:***	

* Please fill out this form per location or attach additional location roster.

Age Range Accepted: please indicate the age range accepted

Other Update: _____

_____

5.
Print Name: _____ ***Signature:*** _____

Title: _____ ***Date:*** _____