



Provider Information Change Form

Return to: Tufts Health Plan
Provider Information Department
705 Mount Auburn Street
Watertown, MA 02472
Fax: 617.972.9044
Email: Provider_Information_Dept@tufts-health.com

Contact Name: _____ Contact Phone: _____
Provider Name: _____ Provider NPI: _____
Effective Date of Change: _____

Address Change 1 Type of change: Add address Remove address

Street _____ City _____ State _____ ZIP _____
Handicap access? Yes No Telephone #: _____ Email address: _____
Check appropriate type of address: Practice address Payment address Mailing address

Address Change 2 Type of change: Add address Remove address

Street _____ City _____ State _____ ZIP _____
Handicap access? Yes No Telephone #: _____ Email address: _____
Check appropriate type of address: Practice address Payment address Mailing address

Other Changes

Name Change _____
 Tax ID Number (W-9 form required) _____
 Panel Restrictions/Closings/Opening _____

Covering Providers PLEASE ATTACH A LIST
 Office Hours _____
 Other _____

Signature authorizing this change: _____ Date: _____

Contact Provider Information at 617.972.9495 if you have any questions. Allow 7-10 business days for your change to be processed. If you would like confirmation that this change has been completed, provide an email address where we can send confirmation: _____.

For PI Dept Internal Use Only: PI Specialist _____ Date: _____