



**CURRENT PRACTICE INFORMATION**

Practice name/individual name: \_\_\_\_\_

(Please circle one ↑)

Practice ID/individual ID: Keystone First CHC ID: \_\_\_\_\_ PPID# \_\_\_\_\_

(Please circle one ↑)

\_\_\_\_\_  
Contact person name (please print clearly)      Phone      Fax      Email address

\_\_\_\_\_  
Authorizing signature (provider/office manager)      Today's date      Effective date of change  
Change will not be completed without signature.

**PROVIDER CHANGE INFORMATION**

Provide complete information. This request will be processed for Keystone First Community HealthChoices (CHC). If any of these changes result in a change on your W-9, you must submit a copy of your W-9 with this change form.

Type of change (please check all that apply):

- Adding an office location       Fax change       Phone number change  
 Changing an office location       Name change only       Other (attach documentation)

**PREVIOUS OFFICE INFORMATION**

\_\_\_\_\_  
Keystone First CHC Provider ID

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street address

\_\_\_\_\_  
City      State      ZIP

\_\_\_\_\_  
Service counties

**NEW OFFICE INFORMATION**

\_\_\_\_\_  
Keystone First CHC Provider ID

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street address

\_\_\_\_\_  
City      State      ZIP

\_\_\_\_\_  
Service counties

**BILLING LOCATION CHANGE**

\_\_\_\_\_  
Street address 1

\_\_\_\_\_  
Phone      Fax      Email address

\_\_\_\_\_  
Street address 2

\_\_\_\_\_  
Federal tax ID

\_\_\_\_\_  
Street address 3

**(Note: A change in federal ID requires a new W-9.)**

\_\_\_\_\_  
City      State      ZIP

**CHANGE OF OWNERSHIP**

\_\_\_\_\_  
Legal business name of new owner and federal tax ID (requires new W-9)      Effective date of ownership

Please mail this change form and supporting documents to Keystone First CHC, Provider Contracting Department, 200 Stevens Drive, Philadelphia, PA 19113

Coverage by Vista Health Plan, an independent licensee of the Blue Cross and Blue Shield Association.