Hometown Health

Senior Care Plus

A Medicare Advantage Plan from Hometown Health.

DEMOGRAPHIC CHANGE FORM

DATE: _____

PRACTICE NAME: _____ **TAX ID** _____

NAME AND CONTACT INFORMATION OF INDIVIDUAL COMPLETING THIS FORM:

CONTACT / TITLE _____

ADDRESS _____
Street City ST Zip

PHONE _____ FAX _____ EMAIL _____

DEMOGRAPHIC INFORMATION BEING CHANGED:

CHANGE EFFECTIVE DATE: _____

This change affects all providers historically at this location? **Yes** **No**

If no, please list the providers within your group affected by this change:

_____

_____

_____

ADDRESS BEING CHANGED:

_____
Street

_____
City ST Zip Phone Fax

REASON FOR CHANGE:

☐ **Phone number change only** ☐ **Fax number change only**

☐ **Location closed; no new location** ☐ **Location closed – moved to new location** (see below)

☐ **Location move for providers listed above; location not closed** ☐ **Other** (see below)

If new address, please list below:

ADDRESS: _____
Street

_____
City ST Zip Phone Fax

Additional Comments:

_____

UPON COMPLETION, PLEASE FAX TO HOMETOWN HEALTH AT: 775-982-8003

HTHProviderRelations@hometownhealth.com