MUNICIPAL HEALTH BENEFIT FUND
PROVIDER CHANGE FORM

***Please be advised: The effective date stated on this form will be the effective date entered in our system.**

PROVIDER INFORMATION

Provider Name		**Effective Date**	
Individual NPI		**Submitted by**	
Provider Specialty		**Contact Number**	

SECTION I: **Addition or Termination of Providers to an Active Contract**

Add the above listed provider to: (If adding to more than 1 location, use separate form for each location)

Tax ID Number:	
Clinic Name:	
Physical Address:	
Clinic Phone Number:	
Billing Address:	
Billing Fax Number:	

Remove the above listed provider from:

Tax ID Number:	
Clinic Name:	
Physical Address:	
Clinic Phone Number:	
Billing Address:	
Termination Date:	

Send Completed Forms to: mhbfproviderrelations@arml.org

SECTION II: Address Change

Current Address:

Street:	
PO Box:	
City, State:	
Zip Code:	
Phone Number:	

New Address:

Street:	
PO Box:	
City, State:	
Zip Code:	
Phone Number:	
Effective Date:	

SECTION III: Tax Identification Number Change (and or) Legal Name Change *Attach Updated W-9*

Current Tax ID Number/ Name Information:

Tax ID Number:	
Legal Name:	
Address:	
City, State, Zip Code:	
Termination Date:	

New Tax ID Number/ Name Information:

Tax ID Number:	
Legal Name:	
Address:	
City, State, Zip Code:	
Effective Date:	

Email form to MHBF Print Form Clear Form

Send Completed Forms to: mhbfproviderrelations@arml.org