



## Provider Information Form (PIF)

Providers can complete and submit this form to update their provider data file. Please type or print all of the information on this form. E-mail, fax or mail the completed form and any additional documentation to:

Email: [SenderoProviderUpdates@SenderoHealth.com](mailto:SenderoProviderUpdates@SenderoHealth.com)

Fax: (512) 901-9704

Mail: Sendero Health Plans, 2028 East Ben White Blvd., Ste 400, Austin, TX 78741

Provider Name: <i>As noted in the Provider Directory</i>	Date:
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<b>TYPE OF ADDS / CHANGES DOCUMENTED (Check Appropriate Box)</b> <input type="checkbox"/> Add New Provider <input type="checkbox"/> Change of address <input type="checkbox"/> Change of Provider Status, to include Effective Date (e.g., termination from plan, moved out of area) <input type="checkbox"/> Call Covering Physician (Please indicate in the comments section) <input type="checkbox"/> Other (please indicate in the comments section)	<b>PCP Panel Status: (30 day notice req)</b> <input type="checkbox"/> Do not list in Directory <input type="checkbox"/> Closing Panel <input type="checkbox"/> Opening Panel <input type="checkbox"/> Accepting existing patients only
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Physician National Provider Identifier (NPI):  
 Group National Provider Identifier (NPI) :

<b>Physical Address:</b>		<b>The Physical address cannot be a PO Box Number</b>	
Street:		City:	
County:	State:	Zip Code:	
Telephone: (     )     -	Fax Number: (     )     -		

Email address:

<b>Secondary Physical Address:</b>		<b>The Physical address cannot be a PO Box Number</b>	
Street:		City:	
County:	State:	Zip Code:	
Telephone: (     )     -	Fax Number: (     )     -		

**Remittance/Mailing Address: All Providers who make changes to the Remittance/Mailing address  
 Must submit a copy of the W-9 form along with this PIF.**

Street:		City:	
County:	State:	Zip Code:	

**Provider Demographic/Directory Information:**

Languages Spoken other than English:	Office Hours by Location
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Specialty:

Tax ID Number:  
 Effective Date:  
 Provider Name: *As Reported to the IRS:*

Comments:

<b>Provider Signature:</b>	<b>Date:</b>
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<b>Provider Representative (update per office contact):</b>	<b>Date:</b>
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## **Instructions for Completing the Provider Information Form (PIF)**

**Form should be typed and forwarded to the Network Management team (see contact information below).  
No updates will be completed without initial review by the Network Management Team.**

### **Signatures:**

- The Provider signature is required on the Provider Information Form for any update involving change to billing ID, or panel closing.
- A signature by the authorized representative of a practice or facility is acceptable for all other requested changes. Provider Rep may submit changes to demographic data and add of provider to practice.

### **Tax Identification Number (TIN):**

- TIN changes for individual practitioner provider numbers can only be made by the individual to whom the number is assigned.
- Performing providers in a group cannot change the TIN.
- The W-9 form is required for all name and TIN changes.

### **General:**

- *E-mail, Fax or Mail the completed form to:*

[SenderoProviderUpdates@SenderoHealth.com](mailto:SenderoProviderUpdates@SenderoHealth.com)

*Fax: (512) 901-9704*

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Austin, TX 78741**