

Effective Date of Update:							
Type of Update: <input type="checkbox"/> Change <input type="checkbox"/> Addition <input type="checkbox"/> Termination <input type="checkbox"/> Info Only							
<u>CURRENT</u> Information (Complete this section in its entirety, no exceptions)				<u>NEW</u> Information (Complete this section in its entirety, no exceptions)			
Provider Name				Provider Name			
Group Name				Group Name			
TIN				TIN			
Primary Address				Primary Address			
City, State		Zip		City, State		Zip	
Phone		Fax		Phone		Fax	
Mailing Address				Mailing Address			
City, State		Zip		City, State		Zip	
Phone		Fax		Phone		Fax	
Pay Claims To Address				Pay Claims To Address			
City, State		Zip		City, State		Zip	
Phone		Fax		Phone		Fax	
Notes/Comments				Notes/Comments			
Submitted By:				Title	Phone:		
Email to: provider.services@mynmhc.org or fax to: 1-888-282-3483, ATTN: NMHC Provider Services Department							
NMHC Use ONLY							
<input type="checkbox"/> Copy Given to PRS Rep <input type="checkbox"/> Updated in IntelliCred by: _____ <input type="checkbox"/> Filed Electronically in Correspondence in Provider File							