

Demographic Change Form



If you need to advise us of demographic changes made at your practice, please complete and email this form to database@hcpipa.com or fax to (516) 746-8473.

Provider Information

HCP ID #:	Provider NPI #:	
Provider Name:	Provider Email:	
Primary Contact Name:	Phone #:	Email:

Service Information

Please indicate offices in order. If you are replacing a location, complete "Deactivate a Location" section

	Primary Office			Secondary Office		
Group Name						
Street / Suite #						
City, Street, Zip						
Phone #						
Fax #						
Practice Type	Primary Care ____	Specialist ____	Both ____	Primary Care ____	Specialist ____	Both ____
Office Hours <small>This section applies to Primary Care only. Per CMS, providers must work at least 16 hours per week, per location, not exceeding 48 total hours across all sites. Office hours cannot overlap between locations.</small>	Mon	Tue	Wed	Mon	Tue	Wed
	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____
	Thu	Fri	Sat	Thu	Fri	Sat
	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____
	Sun			Sun		
____ - ____			____ - ____			

	Primary Billing Address	Secondary Billing Address
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Tax ID		
Vendor/Group NPI #		
Street / Suite #		
City, State, Zip		
Phone #		
Fax #		
EMR Type:		

Deactivate a Location

	Deactivate Primary	Deactivate Secondary
Group Name		
Tax ID		
Street / Suite #		
City, State, Zip		

Demographic Change Form



Use this page to update, add, and/or deactivate additional offices.

Provider Information

HCP ID #:	Provider NPI #:	
Provider Name:	Provider Email:	
Primary Contact Name:	Phone #:	Email:

Service Information

Please indicate offices in order. If you are replacing a location, complete "Deactivate a Location" section below.

	Additional Office 1			Additional Office 2		
Group Name						
Street / Suite #						
City, Street, Zip						
Phone #						
Fax #						
Practice Type	Primary Care ____	Specialist ____	Both ____	Primary Care ____	Specialist ____	Both ____
Office Hours <small>This section applies to Primary Care only. Per CMS, providers must work at least 16 hours per week, per location, not exceeding 48 total hours across all sites. Office hours cannot overlap between locations.</small>	Mon	Tue	Wed	Mon	Tue	Wed
	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____
	Thu	Fri	Sat	Thu	Fri	Sat
	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____	____ - ____
	Sun			Sun		
____ - ____			____ - ____			

	Additional Office 1 Billing Address	Additional Office 2 Billing Address
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Tax ID		
Vendor/Group NPI #		
Street / Suite #		
City, State, Zip		
Phone #		
Fax #		
EMR Type:		

Deactivate a Location

	Deactivate Additional Office 1	Deactivate Additional Office 2
Group Name		
Tax ID		
Street / Suite #		
City, State, Zip		

SITE ASSESSMENT TOOL

Please complete a form for each ACTIVE office location
(Be sure to make additional copies, one for each location)

Practice Name: _____

Street: _____

City/State/Zip Code: _____

Office Phone#: _____ Office Fax#: _____ Tax ID#: _____

NOTE: For any **NO** response, please provide an explanation on a separate sheet of paper.

AMERICAN DISABILITY ACT

1. Does this office meet ADA accessibility requirements? Yes No

PHYSICAL ACCESSIBILITY

2. Facility entry is handicapped accessible. Yes No

3. Bathrooms are handicapped accessible. Yes No

4. Exam Tables are handicapped accessible. Yes No

5. Office Hours are posted in office. Yes No

PHYSICAL APPEARANCE

6. Floors, walkways, rooms, entrances and exits are clean and free of clutter? Yes No

7. Bathrooms and hand washing areas have hot water, soap and paper towels/air dryers? Yes No

8. Sufficient lighting (indoors and outdoors)? Yes No

9. Fire extinguishers, smoke detectors and sprinklers are present, accessible and in working order? Yes No

10. Evacuation plan and/or EXIT sign is displayed? Yes No

ADEQUATE SPACE IN WAITING AREA AND EXAM ROOMS

11. Adequate seating in waiting room (3 chairs per physician)? Yes No

12. Exam room equipped with adequate space/privacy? Yes No

ADEQUACY OF MEDICAL/TREATMENT RECORD KEEPING

13. Medical records are filed securely, easily accessible and limited to authorized personnel? Yes No

14. All entries are legible, signed and dated? Yes No

15. HIPAA Privacy Notice is visibly displayed and distributed to all patients? Yes No

I, the undersigned, attest that the information on this form is complete and accurate.

Signature and Title of Authorized Personnel

Date

Request for Taxpayer Identification Number and Certification

Go to www.irs.gov/FormW9 for instructions and the latest information.

**Give form to the
requester. Do not
send to the IRS.**

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See Specific Instructions on page 3.	1	Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)		
	2	Business name/disregarded entity name, if different from above.		
	3a	Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only one of the following seven boxes. <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C corporation <input type="checkbox"/> S corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) _____ Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) _____	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____ <i>(Applies to accounts maintained outside the United States.)</i>	
	3b	If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions <input type="checkbox"/>		
	5	Address (number, street, and apt. or suite no.). See instructions.	Requester's name and address (optional)	
	6	City, state, and ZIP code		
	7	List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Social security number									
				-					
or									
Employer identification number									

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person	Date
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they