Taxpayer Identification Number Change Form

Please fax to 801-270-3066, Attn: Provider Relations

The letter certifies that I, _____, am hereby changing my
Provider Name (please print)
Taxpayer Identification Number (hereafter "TIN") from _____ to

_____.

TIN effective date: _____.

Note: This change of TIN is effective with EMI Health as contracted, the first day of the month following approval.

Billing NPI#: _____ Individual NPI#: _____

Physical Address: Billing Address:

_____ _____

_____ _____

_____ _____

Phone #: E-mail Address:

_____ _____

With this change of TIN, I wish to terminate the previous TIN indicated above. I understand and agree that a new contract will be required with EMI Health and that claims will be paid to the TIN submitted on the claim, subject to EMI Health's approved contract effective date for that TIN.

Signed,

_____ _____

Signature of Provider Date