

Behavioral Health Connecticut, LLC

CHANGE OF INFORMATION NOTIFICATION

DATE:	
PROVIDER NAME:	
GROUP NAME: (If Applicable)	
ADDRESS:	
OFFICE PHONE NUMBER:	
BILLING/MAILING ADDRESS: (If Different)	
BILLING PHONE NUMBER:	
FAX NUMBER:	
TAX ID NUMBER: (For this location)	

*Circle One

Replacement location? Yes No

Add this location? Yes No

Please complete this form for each additional location and indicate whether this new information will replace or add to your present locations. For claims payment purposes, a W-9 form is required to accompany this form.

Fax changes to: Provider Relations Department (860) 704-6212 or mail to:

**Behavioral Health Connecticut
Provider Relations Department
P.O. Box 775
Middletown, CT 06457**

*****Please call BHC at 1-800-741-4443 for additional assistance*****