



Demographic Update Form – Individual (Rev. 02/2022)

To update information on an existing provider record, please complete and return this form and supporting documents via: EMAIL: ProviderOps@MDXHawaii.com
FAX: 808-532-3396 – Provider Network Ops

Please contact Provider Services with any questions:
Phone: 808-532-6989 (O’ahu) 1-800-851-7110 (Neighbor Islands)

PROVIDER NAME: _____

TIN: _____

Please check the appropriate change type and complete appropriate fields.

NAME CHANGE

New Name _____ Effective Date: _____

ADDRESS NEW (Please attach a copy of your W-9)

Applies to: Pay-To/Billing Address Practice Address Effective Date: _____

Street/PO Box: _____ Phone: _____

City, State: _____ Fax: _____

Zip Code: _____ Email: _____

Hours of Operation: _____

Is location accessible to persons with disabilities? Yes No

ADDRESS TERMINATION

Applies to: Pay-To/Billing Address Practice Address Effective Date: _____

Street/PO Box: _____ Phone: _____

City, State: _____ Fax: _____

Zip Code: _____ Email: _____

TIN CHANGE (Please attach a copy of your W 9 for new TIN)

New TIN: _____ Effective Date: _____

Terminate TIN: _____ Effective Date: _____

CONTACT INFORMATION NEW (Please attach a copy of your W-9)

Applies to: Pay-To/Billing Address Practice Address Effective Date: _____

Email: _____ Phone: _____ Fax: _____

CONTACT INFORMATION TERMINATE

Applies to: Pay-To/Billing Address Practice Address Effective Date: _____

Email: _____ Phone: _____ Fax: _____

PRACTICE PANEL Effective Date: _____

Accepting New Patients Commercial Humana HMO Humana PPO UHC PPO

Closed Panel-Existing Patients Only Commercial Humana HMO Humana PPO UHC PPO

OTHER _____

REQUIRED SUBMITTER INFORMATION

Name of person completing this form: _____ Date: _____

Email: _____ Phone: _____