CalOptima
A Public Agency
Better. Together.

Provider Demographic Change Request

Rendering Provider Name	
Rendering Provider NPI	
Provider Type	☐ Provider ☐ Group with Practitioner(s) ☐ Facility
Group Name (if applicable)	
Group Billing NPI (if applicable)	
Change Request	☐ Service Address Effective Date: _____ ☐ Remit Address/W-9 Effective Date: _____ ☐ Phone or Fax ☐ Other (please explain)

Current Service Address		**City/State/ZIP**	
Current Remit Address		**City/State/ZIP**	
Current Phone			
New Service Address		**City/State/ZIP**	
New Remit Address		**City/State/ZIP**	
New Phone		**New Fax**	
Tax ID Number (Include W-9)			

Contact Person	**Name:**
	Phone:
	Email:

Forward completed form along with a W-9 to Provider Data Management Services via fax at 714-954-2330 or email to provideronline@caloptima.org.

All completed requests received will be processed within seven business days.

If you have any questions, contact Provider Data Management Services at **714-246-8468**. All calls will be returned within one business day.

If approved for COVID-19 Emergency Medi-Cal Provider Enrollment, please include the Department of Health Care Services (DHCS) approval letter.

Thank you,

Provider Data Management Services