Vantage® Preferred Provider Organization
A PPO for Self-Funded or Fully Insured Employee Health Benefit Plans

Provider Change of Status Form

Provider Name: ____

Effective date of change(s): ____________________

Please check all that apply:

____ Tax ID number change

____ Address change

____ Practice name change

____ Joining another practice

____ Moving from service area

____ Retiring

____ Other (please describe below):

____

____

Please detail change(s) below:

Tax ID #: ______________________________________

Practice Name: ____

Street: ____

City/State/Zip: ____

Phone and Fax: ____

Please fax this form to (814) 337-8777