VENTURA COUNTY
HEALTH CARE PLAN

Provider Update Request Form

Current Practice information

Effective Date of Change: _____ ☐ Group Practice ☐ Individual Provider

Name of Group/Individual Provider: _____

NPI #: _____ TAX ID #: _____

Practice Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____ Email: _____

Provider Change Information

Type of Change:

☐ Address/Billing Change ☐ Telephone/Fax Number ☐ Email Address

☐ Closed/Open to New Members ☐ NPI Change ☐ Tax ID Change

☐ Adding a Location ☐ Adding a Provider ☐ Terming a Provider

New Office Information:

Name of Group/Individual Provider: _____

NPI #: _____ Tax ID #: _____

Practice Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____ Email: _____

Providers – Please list providers that have been added or deleted from your practice.

Last Name: _____ First: _____ Middle: _____ Degree: _____

NPI #: _____ License #: _____

Last Name: _____ First: _____ Middle: _____ Degree: _____

NPI #: _____ License #: _____

Change of Ownership:

Legal Business Name of New Owner: _____

Tax ID Number of New Owner (Requires W-9 Form): _____

Authorized by:

Name: _____ Title: _____

Signature: _____ Date: _____

Please email, mail, or fax this change form and supporting documentation to: Provider Services Department at VCHCP.ProviderServices@Ventura.org; 2220 E. Gonzales Rd. #210-B, Oxnard, CA. 93036; Fax: 805-981-5051.