Provider Change of Address Form

Provider/Group Name: _____ Date: _____

Tax ID Number: _____

Physical Address	Billing Address	Contract Mailing Address
		***Must list a **PHYSICAL** address/location
☐ No Change	☐ No Change	☐ No Change
Contact Person:	Contact Person:	Contact Person:
Phone Number:	Phone Number:	Phone Number:
Fax Number:	Fax Number:	Fax Number:
Email:	Email:	Email:

Verification: I verify that the above information is accurate and that I have legal authority to modify the above information under the said tax identification number. I understand that modifications to this information will affect the address of future payments, notification of physical location to members, and other uses of this information by OGB.

Print Name	Title	Signature

For Office Use Only

PROT: _____ Date: _____

PROI: _____ Date _____

PLEASE MAIL OR FAX TO:
State of LA, Office of Group Benefits
Attn: Provider Services
P. O. Box 44036
Baton Rouge, LA 70804
Fax: (225) 925-6717