W-9 Change Request Form

PacificSource

Important notice regarding tax ID name and/or tax ID changes:

- Tax ID name changes and Doing Business As (DBA) name changes require a signed contract amendment and a system update.
- Tax ID changes require a system update.
- Acquisition and assignment changes require the Ownership and Acquisition Change Request Form to be fully completed with all required documentation.

Without proper documentation, changes will not be processed. Please make sure to submit the required documentation for requests.

Provider entity's current information

Entity name _____

Tax ID number _____ Term date _____

Tax ID name (Line 1 of W-9) _____ DBA name (Line 2 of W-9) _____

Type I NPI _____ Type II NPI _____

Provider entity's requested change

Entity name _____

Tax ID number _____ Effective date _____

Tax ID name (Line 1 of W-9) _____ DBA name (Line 2 of W-9) _____

Type I NPI _____ Type II NPI _____

Justification of change

Entities are required to inform the payor of the reason for the change.

Providers and practices going through W-9 changes, an acquisition, or the acquiring of another practice must report any changes.

All changes must be reported at least 30 days before the effective date. If you don't provide the information requested in this form by the deadline, PacificSource may take action up to and including termination of your contract with us.

Note: Delegated entities must submit updates through the entity directly. For example, those that belong to an Independent Provider Association (IPA) must submit updates through the IPA.

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Required documentation

Please complete the following documents and send them to ProviderContracting@PacificSource.com:

- W-9 Change Request Form
- Provider W-9
- Provider Roster

Note: If you don't provide all required documents, your request will be considered incomplete. If the information requested in this form is not submitted within 30 days of the effective date of your W-9 change, PacificSource may take action up to and including termination of your contract with us.

Attestation

I understand that noncompliance with any of the above may affect my eligibility to be an in-network provider with PacificSource Health Plans, PacificSource Community Health Plans (Medicare), and/or PacificSource Community Solutions (Medicaid). I attest that I understand the requirements of compliance.

Provider entity's signature _____

Date _____