THE HSC HEALTH CARE SYSTEM
Health Services for Children with Special Needs, Inc. (HSCSN)

Demographic Provider Change Form

(Include only the information that has changed)

Please select the type of change:

Change From

Group Practice Name _____
Provider Name _____
Practice Address _____
City _____ State _____ Zip Code _____
Telephone # _____ Fax # _____ Email _____
TAX ID # _____
Specialty _____ Accepts New Members Yes ( ) No ( )

Add

Group Practice Name _____
Provider Name _____
Practice Address _____
City _____ State _____ Zip Code _____
Telephone # _____ Fax # _____ Email _____
TAX ID # _____
Specialty _____ Accepts New Members Yes ( ) No ( )

Delete

Group Practice Name _____
Provider Name _____
Practice Address _____
City _____ State _____ Zip Code _____
Telephone # _____ Fax # _____ Email _____
TAX ID # _____
Specialty _____ Accepts New Members Yes ( ) No ( )

Please send this form to Tthompson@hscsn.org or you may fax it to (202) 480-2333, Attn: Provider Services.