

**UNITY MANAGED MENTAL HEALTH PROVIDER CHANGE FORM**

Requestor name: _____	Date:    /    /
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**Provider Information**

Shaded fields are required, in other fields only fill in information that needs to be changed. Please send to:  
Unity Managed Mental Health 1000 Des Peres Road, Ste. 200C St. Louis, MO 63131. Attn: Provider  
Relations or you may fax it to 314-729-4636.

Last Name: _____	First Name: _____	MI: _____
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Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ TIN# \_\_\_\_\_ - \_\_\_\_\_ D.O.B \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Title: MD or DO or Other \_\_\_\_\_ (*Circle One*) State License # \_\_\_\_\_ State: \_\_\_\_\_

Practice Name or Group Name: \_\_\_\_\_

**Mailing Address Change:**

Street Address: \_\_\_\_\_ Suite \_\_\_\_\_

P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ - \_\_\_\_\_ Fax # (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_ Phone # (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

**Billing Address Change**

Street Address: \_\_\_\_\_ Suite \_\_\_\_\_

P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ - \_\_\_\_\_ Fax # (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_ Phone # (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

**Service Address Change**

Street Address: \_\_\_\_\_ Suite \_\_\_\_\_

P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ - \_\_\_\_\_ Fax # (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_ Phone # (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_ Board Certified Yes / NO / NA (*Circle One*)

After Hours Phone # (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

Primary Specialty: \_\_\_\_\_ Secondary Specialty \_\_\_\_\_

Primary Admitting Hospital: \_\_\_\_\_

Secondary Admitting Hospital: \_\_\_\_\_

Indicate Products: Commercial – Medicaid – Medicare –Other (Circle)

Comments: \_\_\_\_\_  
\_\_\_\_\_