



Provider Update/Change Form

Use this form to correct or add information contained in your listing.

Please print legibly.

RMHP Provider Number (include suffix): _____

Provider Name (for validation): _____

Complete only the fields that require correction:

Address: _____

County: _____ Telephone Number: _____

Practice Name: _____

UPIN or NPI Number: _____ Fax Number: _____

Date of Birth: _____ Sex: Male Female

Specialty: _____ Languages: _____

Contact name for questions: _____

Telephone number for questions: _____

Fax completed request to RMHP Provider Relations at 970-244-7957.