

Office Information	
Office Name:	Office Contact:
Old Street Address:	City/State/Zip Code:
New Street Address:	City/State/Zip Code:
Phone:	Email:
Fax:	Effective Date of Change:
<i>Please note: We need an updated staff roster and W-9 to process any updates. Please submit the information with this form.</i>	
Billing and Remittance Information	
Payee Name:	Tax ID #:
Street Address:	City/State/Zip Code:
Contact Name:	Phone:
Email:	Fax:
Information	
<ul style="list-style-type: none"> • Please complete the above fields and submit this form with a copy of the W-9 and your staff roster. You may submit this form via fax or email with the information below. <ul style="list-style-type: none"> ○ Email: providerservices@holistahealth.com ○ Fax: 866-231-6344 • Once submitted, it may take up to 2 business days for a response. • All updates are available on our website: atapwp.therapyadmin.com • Questions may be directed to 888-560-6855, Monday – Friday 8am to 4pm CT. 	