



**Instructions**

Please type or print in black ink. The completed form should be sent to:

**Mail:** Uniform Medical Plan  
P.O. Box 91118  
Seattle, WA 98111-9218

**Fax:** Attn: Credentialing Dept  
206-521-2001

Note that certain fields are **required** even if not changing. If you have questions or need assistance, call **UMP Contracting & Credentialing at 1-800-292-8092.**

**Contact Information for Person Completing This Form (required)**

Name \_\_\_\_\_ Change effective date \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

\_\_\_\_\_  
Signature of person completing this form

\_\_\_\_\_  
Date completed

If you are a: **Type 1 Provider** or **Type 2 Provider**

**National Provider Identifier (NPI) (required)**



**Old information**

**New information**

	<b>Old information</b>	<b>New information</b>
<b>*Provider Name</b>		
<b>Credentials</b> (such as M.D. or D.C.)		
<b>Specialty</b>		
<b>*Tax I.D. #</b> (if changing, include W-9 form)		
<b>Practice Name</b> (if applicable)		
<b>Practice Location:</b> Street address		
City/State/ZIP		
Phone		
Fax		
<b>Mailing:</b> Street address		
City/State/ZIP		
<b>Billing:</b> Street address		
City/State/ZIP		
Phone		
Fax		

\*Required field

Comments may be written on the back,  
or attached on a separate sheet.

**Questions? Call UMP Credentialing &  
Contracting at 1-800-292-8092.**