



#### 4. Billing Information (as billed on CMS 1500 field 31 or UB box 2)

Same as Above

Billing Name (as it appears on claims) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ County \_\_\_\_\_

Billing Contact Name \_\_\_\_\_

Billing Contact Email \_\_\_\_\_

Billing Contact Phone \_\_\_\_\_ Billing Contact Fax \_\_\_\_\_

#### 5. Other Changes to Provider Directory

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#### 6. Summary of Changes/Notes

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Form Completed By \_\_\_\_\_

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

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**Return to:** Mail: PO Box 7068, Springfield, OR 97477  
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