



Provider Address Change Form (v1.0)

The Provider Address Change Form is to be used to notify NSHA of a physical change of address for providers subscribed to eResults. Provider signature is required in Section 4 for successful processing.

NOTE: THIS FORM IS TO BE USED TO INFORM US OF CHANGES TO YOUR MAILING ADDRESS ONLY.

THERE WILL BE NO CHANGE MADE TO YOUR CURRENT RESULTS DELIVERY SETUP. IF YOU REQUIRE A CHANGE TO YOUR eRESULTS DELIVERY, PLEASE FILL OUT THE "Re-Routing Request" SECTION OF THE "eResults Request" FORM.

1. Provider Information

Please complete the following section with the required provider information.

Provider Identification	
Full Name: _____ (please print)	Provider PMB #: _____
Main Telephone #: _____	Fax #: _____
E-mail Address: _____	

Clinic Contact – Administration/Front Office (Practice Champion)	
Please provide the contact details of the person at your clinic that will be the primary contact if more information is required or support issues arise.	
Full Name: _____ (please print)	
Main Telephone #: _____	Fax #: _____
E-mail Address: _____	

2. Current Address Information

CURRENT ADDRESS	
Clinic Name: _____	
Clinic Mailing Address: _____ _____ _____	Clinic Billing Address (if different than mailing): _____ _____ _____
Clinic Telephone #: _____	Clinic Fax #: _____

3. New Address Information

NEW ADDRESS	
Clinic Name: _____	
Clinic Mailing Address: _____ _____ _____	Clinic Billing Address (if different than mailing): _____ _____ _____
Clinic Telephone #: _____	Clinic Fax #: _____
Address Change Effective Date (mm/dd/yy): _____	

4. Provider Signature for address change - **Mandatory**

Once the appropriate sections on the previous page(s) have been completed please print your name and provide your signature below.

Name (print): _____

Signature: _____

5. Form Submission

Please fax the completed request form to the eResults Service Delivery Team. All questions related to the form can be directed to the email supplied below.

eResults Service Delivery Team

Fax: (902) 407-3019

email: PHCCA@nshealth.ca