

**Provider Information Management System (PIMS) Update Form
REQUEST FOR PERMISSION TO PRECERTIFY ONLINE**

PROVIDER'S GROUP INFORMATION:

Practice Group Tax Number: _____

Practice Group Name: _____

PHYSICAL Address: _____

BILLING Address: _____

Telephone Number: _____

Primary Specialty: _____

Secondary Specialty (If Applicable): _____

Effective Date: _____

PRACTITIONER'S INFORMATION:

Practitioner's SSN: _____

Practitioner's Name: _____

Practitioner's Title (MD, etc.): _____

PHYSICAL Address: _____

BILLING Address: _____

Telephone Number: _____

Primary Specialty: _____

Secondary Specialty (If Applicable): _____

Effective Date: _____