DEMOGRAPHIC CORRECTION FORM

Humana

Provider Information

Provider Name	Date of Birth

Provider Specialty	Provider Number	NPI Number	Tax ID

Primary Office Address			Secondary Office Address		
City	State PR	Zip Code	City	State PR	Zip Code
Telephone Number	Fax Number		Telephone Number	Fax Number	

OFFICE 1	HOURS						
	SUN	MON	TUE	WED	THU	FRI	SAT

OFFICE 2	HOURS						
	SUN	MON	TUE	WED	THU	FRI	SAT

Billing Address (Provider's Signature is required)			Correspondence Address (Provider's Signature is required)		
City	State	Zip Code	City	State	Zip Code

E-Mail Address	Web Page

Contact Name	Contact Phone No.	Contact Fax No.

Provider's Signature	Date	License Number

By signing and dating this document, I certify that this information is accurate, complete, correct and true to the best of my knowledge and submitted as true and correct.

Please return to:
Humana Health Plans of Puerto Rico, Inc.
Attn: Provider's Network & Contracting Department
PO Box 192059
San Juan PR 00919-2059

For Humana's Representative Use Only

Line of Maintenance	Database	Type of Request	Attachment	Effective Date	Requested by (Name and Initials)
☐ Directory ☐ Billing & Correspondence	☐ PMHS ☐ PSP	☐ Add ☐ Update ☐ Terminate	☐ Yes ☐ No		

Correction Action or Comments

For Contract Loading Use Only

Processed by	Date