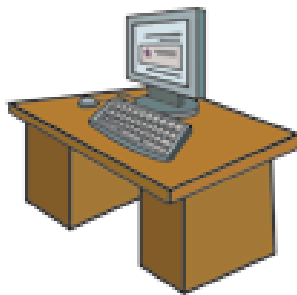


IE ♥ HP

NPI Update Instructions



Created Date: September 2017

NPI Update Instructions

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Login

1. To log into account, go to <https://nppes.cms.hhs.gov/#/>
2. Enter User ID and Password and click on the blue button “SIGN IN”.



Registered User Sign In

Log in to view/update your National Provider Identifier (NPI) record.

User ID ⓘ
I&A User ID, used to access NPPES, EHR & PECOS

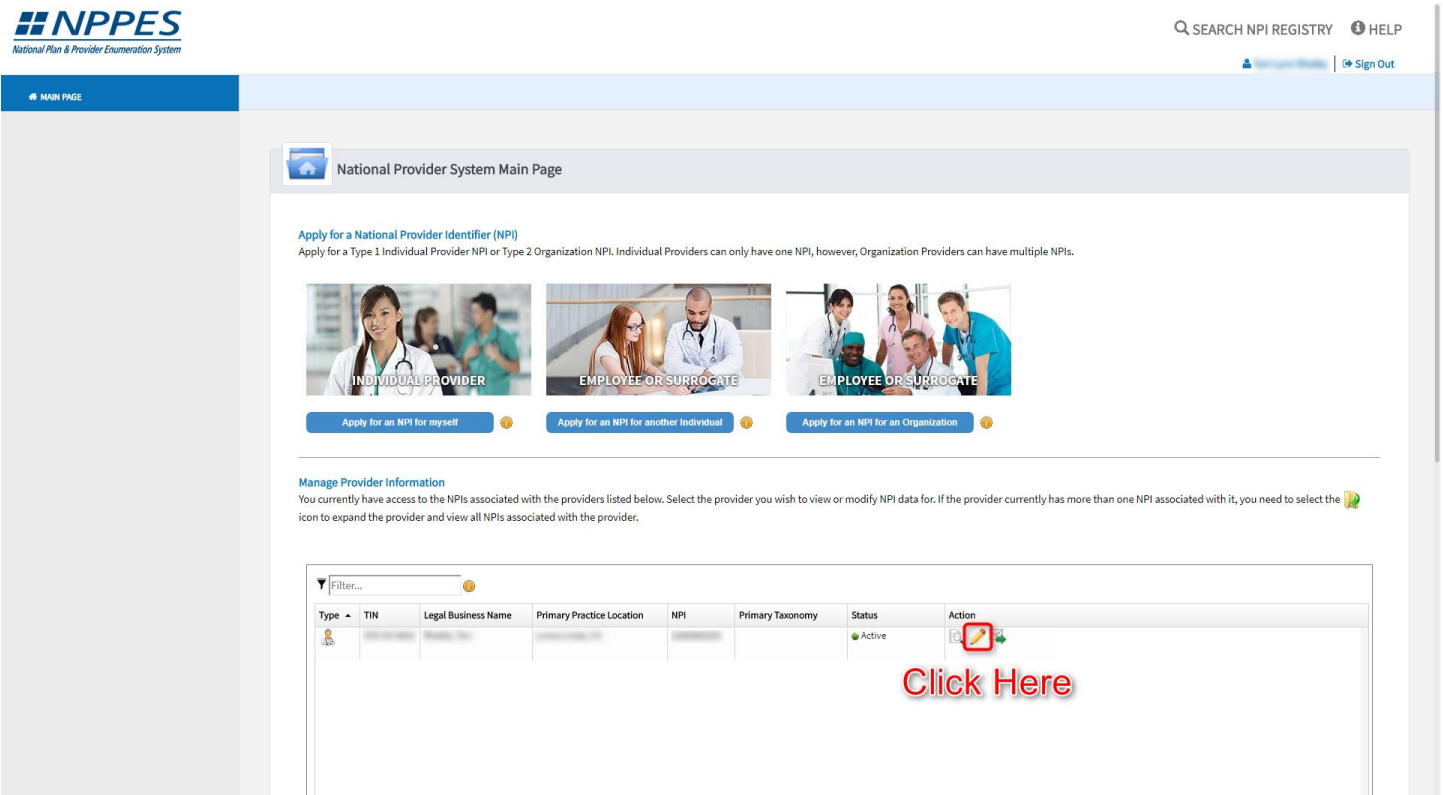
Password

SIGN IN


FORGOT USER ID OR PASSWORD?

*If your User ID is associated with a large number of providers, you could experience a small delay while the application retrieves all NPPES profile related information

3. From the *Main Page*, go to Manage Provider Information section and under “Action”, click on the “Pencil”.



The screenshot shows the NPPES National Provider System Main Page. At the top left is the NPPES logo. At the top right are search and help icons. Below the header is a navigation bar with a 'MAIN PAGE' link. The main content area is titled 'National Provider System Main Page' and contains three application buttons: 'Apply for an NPI for myself', 'Apply for an NPI for another individual', and 'Apply for an NPI for an Organization'. Below these is a 'Manage Provider Information' section with a descriptive paragraph and a table of providers. The table has columns for Type, TIN, Legal Business Name, Primary Practice Location, NPI, Primary Taxonomy, Status, and Action. A red box highlights the pencil icon in the Action column of the first row, with the text 'Click Here' written below it.

Type	TIN	Legal Business Name	Primary Practice Location	NPI	Primary Taxonomy	Status	Action
Individual Provider						Active	

Provider Profile



1. Make sure all required (*) information is filled out



SEARCH NPI REGISTRY HELP

Sign Out

Provider Profile

* Indicates Required fields.
Note: Fields with icon will NOT be publicly available

Provider Name Information:

Prefix: * First: Middle: * Last: Suffix:

Credential(s):(MD, DO, etc.):
M.D.

Other Name:(if applicable)
Prefix: First: Middle: Last: Suffix:

Type of Other Name: Credential(s):(MD, DO, etc.):

Other Identifying Information:

* Date of Birth: * TIN Type: * Tax Identification Number(TIN):
SSN

* State of Birth:(if U.S.): Country of Birth:
CA - CALIFORNIA US - United States

* Gender: Male Female

* Is the Provider a Sole Proprietor? Yes No

Demographic Information(optional)

Ethnicity: No, not of Hispanic, Latino/a or Spanish Origin White

Race: White

Navigation: [< PREVIOUS](#) [NEXT >](#) [SAVE & RETURN TO MAIN PAGE](#)

Click Here

Do not click on the green "Save & Return to Main Page" button.

2. Once confirmed, please scroll to the bottom of the page and click on the blue button "Next"
 - o **NOTE:** Clicking on the green button "Save & Return to Main Page" will not confirm changes.

Address



1. On the *Address* page, go to the Practice Location section and under “Actions”, click on the “Pencil”

Practice Location (only one required)

This is the physical address (cannot be a Post Office Box) where services are rendered. Multiple locations can be entered, but only the primary location is required.

Primary Location	Address	City	State/Province/Region	Country	Office Hours	Languages Spoken	Actions
<input checked="" type="checkbox"/>			CA	US			

Click Here

ADD ANOTHER PRACTICE LOCATION

2. In the *Business Practice Location*, please update and make all necessary changes to your Primary Practice Location. After filling out all required (*) information, click on the green button “Save”.

Business Practice Location

This address(es) is where services are rendered. If the provider has more than one practice location, one must be identified as the primary practice location.

* Indicates Required fields.

Select Type of Address: US Domestic Military Outside US / Foreign

Same as mailing address
 This is my home address
 Primary practice location

* Address Line 1: (Street Number and Name)
[Text Field]

Address Line 2: (e.g. Suite Number)
[Text Field]

* City:
[Text Field]

* State:
CA - CALIFORNIA

* Zip Code:
[Text Field]

Zip Ext:
[Text Field]

* Telephone Number:
[Text Field]

Extension:
[Text Field]

Fax Number:
(000)-000-0000

Languages Spoken: (Multiple languages can be selected)

- English
- Arabic/ العربية
- Armenian/ Հայերեն
- Bengali/ বাংলা
- Chinese/ 中文
- Farsi/ فارسی
- French/ Français
- German/ Deutsch

CANCEL SAVE

Address (Continued)



3. If the system does recognizes your address, please click on the blue button “Accept Standardized Address”

Please do one of the following:

1. Accept the standardized address.
2. Reject the standardized address and keep your input as is.
3. Modify your input in the boxes below and submit for revalidation.

Your input address:

* Address Line 1: (Street Number and Name)

Address Line 2: (e.g. Suite Number)

* City: * State: CA - CALIFORNIA * Zip Code: Zip Ext:

* Comments - Tell us why do you want to use input address:

USE INPUT ADDRESS REVALIDATE ADDRESS

Your standardized address:

ACCEPT STANDARDIZED ADDRESS

Click Here

4. If the system does not recognizes your address, please make necessary changes in the *Your input address* box and click on the blue button “Revalidate Address”

Address NOT FOUND

Please do one of the following:

1. Make Corrections and Select Revalidate Address
2. If input address looks correct, enter an explanation and select Continue

Note: selecting option 2 will cause your application to be delayed to allow for address verification by the help desk team

Your input address:

* Address Line 1: (Street Number and Name)

Address Line 2: (e.g. Suite Number)

* City: * State: CA - CALIFORNIA * Zip Code: Zip Ext:

* Comments - Tell us why do you want to use input address:

REVALIDATE ADDRESS

CONTINUE

Click Here

Address (Continued)



- After accepting standardized address, the address changes made should reflect under *Practice Location*.

Practice Location (only one required)

This is the physical address (cannot be a Post Office Box) where services are rendered. Multiple locations can be entered, but only the primary location is required.

Primary Locati...	Address	City	State/Province/Regl...	Country	Office Hours	Languages Spoken	Actions
<input checked="" type="checkbox"/>			CA	US			

Address changes should display here

1 of 1 items

ADD ANOTHER PRACTICE LOCATION

[PREVIOUS](#) [NEXT](#) **Click Here**

[SAVE & RETURN TO MAIN PAGE](#)

Do not click on the green “Save & Return to Main Page” button.

- Once confirmed, please scroll to the bottom of the page and click on the blue button “Next”
 - NOTE:** Clicking on the green button “Save & Return to Main Page” will not confirm changes.

Other Identifiers



1. The *Other Identifiers* page is optional to fill out. You may **skip** this page and move onto the next section.

Other Identifiers (optional)
Associating other provider identifiers with your NPI is optional.
* Indicates Required fields.
Enter All Other Provider Identifiers
Note: These numbers will be of use in matching your [E] record to Insurers' records so you can continue to be recognized by insurers. If you don't have such numbers, you are not required to obtain them. DO NOT report the Medicare Numbers, Social Security Number (SSN), IRS Individual Taxpayer Identification Number (ITIN) or Employer Identification Number (EIN) in this section.

* Issuer: [dropdown]
* Identification Number: [input] State Issued: (if applicable) [dropdown] [GPE] [SAVE]

Issuer	Other Issuer	State Issued	Identification Number	Actions
--------	--------------	--------------	-----------------------	---------

[GPE] [SAVE]

Endpoint (optional)
Associating an Endpoint with your NPI is optional. If you wish to enter an Endpoint, please fill in the required data.
To Learn more about Endpoint click here. To Learn more about Direct Address click here.

* Endpoint Type: [dropdown] * Endpoint: [input]
* Is provider affiliated to another organization? [dropdown] [GPE] [SAVE]

Endpoint Type	Endpoint	Affiliation Y/N	Affiliation Type	Affiliation Id	Actions
---------------	----------	-----------------	------------------	----------------	---------

[GPE] [SAVE]

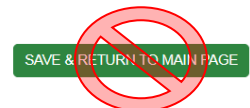
Navigation: [PREVIOUS] [NEXT] [SAVE & RETURN TO MAIN PAGE]

2. Once confirmed, please scroll to the bottom of the page and click on the blue button “Next”

- NOTE: Clicking on the green button “Save & Return to Main Page” will not confirm changes.



Click Here



Do not click on the green “Save & Return to Main Page” button.

Taxonomy



1. If your Taxonomy does not display in the box below, please click on “Choose Taxonomy” and then the green button “Save”.
2. Select a “Primary Taxonomy” by clicking the check box of the row with the correct Taxonomy.

Select Taxonomy here and then click Save (Annotation pointing to the 'Choose Taxonomy' dropdown)

Select Primary Taxonomy by clicking check box (Annotation pointing to the checkbox in the table row)

Once confirmed, Click Here (Annotation pointing to the 'NEXT' button)

Do not click on the green “Save & Return to Main Page” button. (Annotation pointing to the 'SAVE & RETURN TO MAIN PAGE' button)

Form Fields:

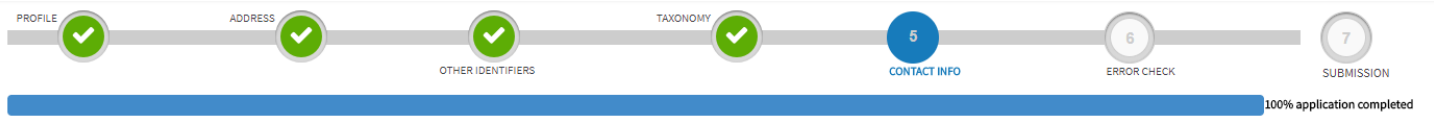
- Choose Taxonomy Filter: Q
- Filter by Taxonomy name or Taxonomy code: [Text Box]
- * Choose Taxonomy: [Dropdown]
- * Classification Name/Specialization: [Text Box]
- License Number: [Text Box]
- State Issued: [Dropdown]

Primary Taxonomy	Taxonomy Code	Taxonomy Type	Group Type	License Number	State	Actions
<input type="checkbox"/>	207R00000X	Internal Medicine			CA	[Trash Icon]
<input type="checkbox"/>	208000000X	Pediatrics			CA	[Trash Icon]

1 of 2 items per page | 1 of 2 items

3. Once confirmed, please scroll to the bottom of the page and click on the blue button “Next”
 - o **NOTE:** Clicking on the green button “Save & Return to Main Page” will not confirm changes.

Contact Info



1. Verify all Contact Information is correct.



Contact Information

All NPI notifications will be sent to the Contact Person Email provided on this page.

* Indicates Required fields.

Contact Person is same as Provider

Contact Person is same as Myself

Prefix: * First: Middle: * Last: Suffix:

Dr. [] [] [] [] []

Credential(s);(MD, DO, etc.) Title/ Position:

M.D. [] []

* Telephone Number: Extension: * Contact Person Email:

[] [] []

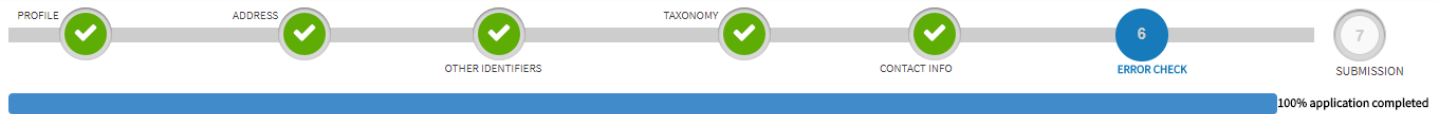
[◀ PREVIOUS](#) [NEXT ▶](#) **Click Here** [SAVE & RETURN TO MAIN PAGE](#)

Do not click on the green “Save & Return to Main Page” button.

2. Once confirmed, please scroll to the bottom of the page and click on the blue button “Next”


- **NOTE:** Clicking on the green button “Save & Return to Main Page” will not confirm changes.

Error Check



1. Once all sections are **green**, you may continue onto the *Submissions* page
2. If any sections are **red**, you will be required to go back to that section and fix any errors.



 **ERROR CHECK**

Note: Please click the NEXT button to submit your application.

Step 1: Provider Profile

✓ COMPLETED: Profile
No Errors Found [REVIEW](#)

Step 2: Address

✓ COMPLETED: Address
No Errors Found [REVIEW](#)

Step 3: Other Identifiers

✓ COMPLETED: Other Identifiers
No Errors Found [REVIEW](#)

Step 4: Taxonomy

✓ COMPLETED: Taxonomy
No Errors Found [REVIEW](#)

Step 5: Contact Information

✓ COMPLETED: Contact Information
No Errors Found [REVIEW](#)

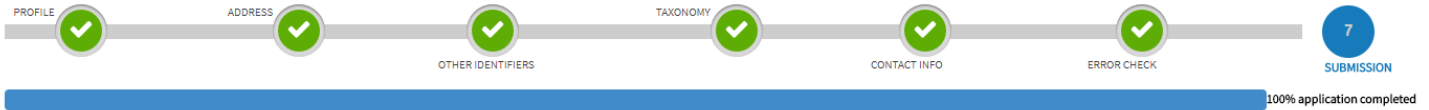
[← PREVIOUS](#) [NEXT >](#) **Click Here**

[SAVE & RETURN TO MAIN PAGE](#)

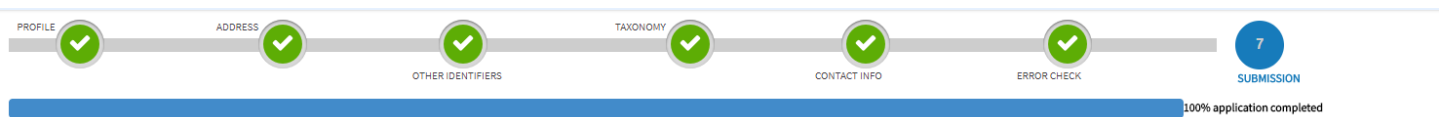
Do not click on the green “Save & Return to Main Page” button.

3. Once confirmed, please scroll to the bottom of the page and click on the blue button “Next”
 - **NOTE:** Clicking on the green button “Save & Return to Main Page” will not confirm changes.

Submission



1. On the *Submission* page, read carefully the disclaimer and then **click on the check box** “I certify that this form is being completed by, or on behalf of, a health care provider as defined at 45 CFR § 160.103” at the bottom of the page.



Submission Certification

* Indicates Required fields.

- I have read the contents of the application and the information contained herein is true, correct and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the [NPI](#) Enumerator of this fact immediately.
- I authorize the [NPI](#) Enumerator to verify the information contained herein. I agree to keep the NPPES updated with any changes to data listed on this application form within 30 days of the effective date of the change.
- I have read and understand the [Privacy Act Statement](#).
- I have read and understand the **Penalties for Falsifying Information** on the [NPI](#) Application / Update Form as stated in this application. I am aware that falsifying information will result in fines and/or imprisonment.

Penalties for Falsifying Information:

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly or willfully falsifies, conceals, or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

I certify that this form is being completed by, or on behalf of, a health care provider as defined at [45 CFR § 160.103](#).

Click Check Box

< PREVIOUS

SUBMIT

Click Submit


SAVE & RETURN TO MAIN PAGE

Do not click on the green “Save & Return to Main Page” button.

2. Once confirmed, please scroll to the bottom of the page and click on the blue button “**Submit**”
 - **NOTE:** Clicking on the green button “**Save & Return to Main Page**” will not confirm changes.

Confirmation

1. After clicking on "Submit", you will be directed to the *Confirmation* page.
2. Print out the *Confirmation* page and keep for your records. An email confirmation will also be sent to you.
3. The Tracking Number will help keep you up-to-date of the status of the changes made to your NPI.

 **Submission Confirmation**

Thank you. Your application will be processed. **Your Tracking number is :** XXXXXXXXXX

You have successfully submitted your Change Request to the NPI application.

An Email confirmation has been sent to the contact person listed on this application. Please be sure to check the "junk" folder.

If you have any questions regarding this application or if the designated contact person doesn't receive the provider's NPI via email within 15 working days, please refer to the [FAQ Menu](#).

If the submitted NPI application contains no errors or additional verifications, the enumeration or changes may be effective within the next 24 hours. If additional verification is required, processing may take up to 30 days.


Provider Name: [REDACTED]
Contact Person: [REDACTED]
Primary Practice Location Address: [REDACTED]
SSN: [REDACTED]
Date Submitted: [REDACTED]
Contact Email: [REDACTED]

To print this page for your reference, click:

PRINT THIS PAGE ← Print this page and keep for your records.

Please Note: This page printout may contain sensitive information.

To View or print this application click:

VIEW PRINTER FRIENDLY VERSION OF APPLICATION 

NPI Enumerator Contact Information

By phone:
1-800-465-3203 (NPI Toll-Free)
1-800-692-2326(NPI TTY)

By e-mail: at.customerservice@npienumerator.com

By mail at:
NPI Enumerator
PO BOX 6059
 Fargo, ND 58108-6059