



## Pennsylvania WC Hearing - Interested Party Update Request

### Health Care Provider (Organizations, e.g., Hospital)

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address City State ZIP+4

FEIN\*: \_\_\_\_\_ (required for update)

### Health Care Professional (Persons, e.g., Doctor)

Name: \_\_\_\_\_

Facility (Provider): \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address City State ZIP+4

Professional License #\*: \_\_\_\_\_ (required for update)