



PROVIDER CHANGE FORM

Today's Date:	Effective Date of Change:
Type of Agreement (please check one):	
<input type="checkbox"/> Solo/individual provider – Name: _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Last First MI </div>	
<input type="checkbox"/> Group provider – Group Name: _____	
<input type="checkbox"/> Facility provider – Facility Name: _____	
Clinic Name (if applicable):	
TAX ID:	Medicaid#:
NPI#:	Taxonomy#:
Licensure:	Facility Accreditation:
State of Licensure:	Group/Facility Contact Person:
Phone Number:	Email Address:

Type of Change (please check appropriate box):

- IF Change of physical addresses, telephone, and/or fax number **(COMPLETE SECTION A)**
- IF Change/add secondary address, telephone, and/or fax number **(COMPLETE SECTION B)**
- IF Change of billing address, telephone, and or fax number **(COMPLETE SECTION C)**
- IF Change of mailing address, telephone, and or fax number **(COMPLETE SECTION D)**
- IF Change of provider status (e.g. moved out of area, capacity changes, etc.) **(COMPLETE SECTION E)**

SECTION A CHANGE IN PHYSICAL ADDRESS, PHONE OR FAX

PLEASE NOTE: THE PHYSICAL LOCATION WILL BE INCLUDED IN THE PROVIDER DIRECTORY AND MUST BE A STREET ADDRESS (NOT A P.O. Box #)

Previous Practice Location:	New Practice Location:
Facility/Clinic Name:	Facility/Clinic Name:
Address:	Address:
County:	County:
Phone #:	Phone #:
Fax:	Fax:
Contact Person:	Contact Person:
Email Address:	Email Address:
Medicaid #	Medicaid #

**** PLEASE NOTE THE STATE OF GA REQUIRES A MEDICAID # FOR EACH LOCATION**

OFFICE HOURS AT THIS LOCATION?

MONDAY		THURSDAY	
TUESDAY		FRIDAY	
WEDNESDAY		SATURDAY	
		SUNDAY	

Identify the percentage of your practice dedicated to treating the following patient populations;
 (Total must equal 100%)

Young Child (0-5 yrs.) ____ % Child (6-11 yrs.)_____% Adolescent (12-17 yrs.) _____%
 Adult (18-64 yrs.) _____% Geriatric (65+) _____%

SECTION B CHANGE IN SECOND LOCATION ADDRESS, PHONE OR FAX

DOES THE TAX ID INFORMATION CHANGE FOR THIS LOCATION? YES NO
IF YES, PLEASE CONTACT YOUR PROVIDER RELATIONS REPRESENTATIVE

Facility/Clinic Name:	
Second Location Address:	
County:	
Medicaid#	
Phone #:	Fax#:
Email Address:	Contact Name:

OFFICE HOURS AT THIS LOCATION?

MONDAY		THURSDAY	
TUESDAY		FRIDAY	
WEDNESDAY		SATURDAY	
		SUNDAY	

Identify the percentage of your practice dedicated to treating the following patient populations;
 (Total must equal 100%)

Young Child (0-5 yrs.) ____ % Child (6-11 yrs.)_____% Adolescent (12-17 yrs.) _____%
 Adult (18-64 yrs.) _____% Geriatric (65+) _____%

SECTION C CHANGE IN BILLING ADDRESS OR BILLING INFORMATION

CHANGES IN BILLING ADDRESS OR INFORMATION REQUIRE A NEW W9. PLEASE CONTACT YOUR PROVIDER RELATIONS REPRESENTATIVE FOR ASSISTANCE.

Facility/Clinic Name:	
New Billing Address:	
Phone #:	Fax #:
TAX ID#	
Exact name reported to the IRS for this Tax ID:	
Medicaid#	
Email Address:	Contact Name:

SECTION D CHANGE IN MAILING ADDRESS

Facility/Clinic Name:	
New Mailing Address:	
Phone #:	Fax #:
Email Address:	Contact Name:

SECTION E CHANGE OF PROVIDER STATUS

Type of change for your practice/facility (moving out of state/retiring, discontinuing a service, closing an office or location, terminating the agreement):

Explanation for the change:

Mail or fax the completed form to: Cenpatico
Fax#: 866-671-3661
504 Lavaca St. #850
Austin TX 78017

Signature

Date