



**PROVIDER CHANGE FORM**

<b>Today's Date:</b> _____		<b>Effective Date of Change:</b> _____	
<b>Type of Agreement (please check one):</b>			
<input type="checkbox"/> Solo/individual provider – Name: _____			
	<b>Last</b>	<b>First</b>	<b>MI</b>
<input type="checkbox"/> Group provider – Group Name: _____			
<input type="checkbox"/> Facility provider – Facility Name: _____			
<b>Clinic Name (if applicable):</b> _____			
<b>TAX ID:</b> _____		<b>Medicaid#:</b> _____	
<b>NPI#:</b> _____		<b>Taxonomy#:</b> _____	
<b>Licensure:</b> _____		<b>Facility Accreditation:</b> _____	
<b>State of Licensure:</b> _____		<b>Group/Facility Contact Person:</b> _____	
<b>Phone Number:</b> _____		<b>Email Address:</b> _____	

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 #)**

<b>Previous Practice Location:</b>		<b>New Practice Location:</b>	
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?**

<b>MONDAY</b>		<b>THURSDAY</b>	
<b>TUESDAY</b>		<b>FRIDAY</b>	
<b>WEDNESDAY</b>		<b>SATURDAY</b>	
		<b>SUNDAY</b>	

**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?**

<b>MONDAY</b>		<b>THURSDAY</b>	
<b>TUESDAY</b>		<b>FRIDAY</b>	
<b>WEDNESDAY</b>		<b>SATURDAY</b>	
		<b>SUNDAY</b>	

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 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):**

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**Explanation for the change:**

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**Mail or fax the completed form to:** Cenpatico  
ATTN: Cindy Smith, Provider Relations Specialist  
1099 N Meridian St., Suite 400  
Indianapolis, IN 46204  
Fax#: 866-912-4249

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date