



<b>Today's Date:</b>		<b>Effective Date of Change:</b>	
<b>Type of Agreement (please select one):</b>			
Solo/Individual Provider – Name: _____			
<b>Last</b>		<b>First</b>	<b>MI</b>
Group Provider – Group Name: _____			
Facility Provider – Facility Name: _____			
<b>Facility 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 (i.e. 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 #	

**OFFICE HOURS AT THIS LOCATION?**

MONDAY		FRIDAY	
TUESDAY		SATURDAY	
WEDNESDAY		SUNDAY	
THURSDAY			

**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		FRIDAY	
TUESDAY		SATURDAY	
WEDNESDAY		SUNDAY	
THURSDAY			

**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 REQUIRES A NEW W9**

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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**Fax the completed form to:**

Cenpatico  
Network Development  
3200 Highlands Parkway SE Suite 200  
Smyrna, GA  
Fax#: 866-532-8837

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Signature

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Date