PROVIDER CHANGE OF INFORMATION FORM

Group Name:_____ **Group NPI/Taxonomy:**_____

Provider Name: _____

Provider NPI (s)/ Taxonomy(s) affected by the change*: _____

_____

** Please note: Requested changes will apply to all Medicaid IDs associated with the NPI/Taxonomy combinations.*

Old Service Address:	**New or Additional Service Address:**	
		Phone:
Old Pay - To Address:	**New Pay – To Address:**	
		Phone:
Old Mail - To Address:	**New Mail - To Address:**	
		Phone:
	Email:	Fax:
Old Billing Service Address:	**New Billing Service Address:**	
		Phone:

☐ **Change in Ownership Interest or Corporate Status: (Requires New W-9)**

- New Owner's Name(s):_____
- Address: _____
- Date of Change of Ownership Interest: _____
- Process by which change occurred: (i.e. merger, sale, gift, etc.) _____
- New Corporate Status: _____

☐ **Change to Certification:**

- Previous Certification: _____
- Current Certification: _____
- Date of Change: _____

Authorized Signature: _____ **Date:**_____

(Signature required to process change)

Print Name and Title:

_____

- Please attach a separate piece of paper if necessary. Thank you for your cooperation.
- Please either FAX Change of Information Form to **(401) 784-3892** or mail to the following address within 35 days of the event prompting the reporting obligation:

DXC Technology – Provider Enrollment Unit
PO Box 2010 Warwick, RI 02887-2010