



PROVIDER CHANGE OF INFORMATION FORM

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: _____
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: _____

Notification of Adverse Action to License:

- Action taken: _____
- By what Agency: _____
- Date action effective: _____

Notification of Bankruptcy Filing:

- Date of filing: _____
- Type: _____
- Attorney Name and Address: _____
- Trustee Name and Address: _____

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:

**Hewlett Packard Enterprise – Provider Enrollment Unit
PO Box 2010 Warwick, RI 02887-2010**