

### Facility Add or Change Form

Please complete this form for new providers and to submit any changes in office location, telephone, fax, Tax ID number, etc.

- To avoid a delay in processing, please complete this form with all information requested.
- All changes require 90-120 days for implementation.
- **Please attach populated W9 and example copy of CMS1500 or UB claim form**
- Return to fax 239.659.7791. >> Please explain change: check all that apply:

New Facility ☐ New TID ☐ New Billing ☐ New Primary ☐ New Additional Address ☐ New phone/fax ☐  
Change/add services ☐ Add Additional TIN ☐ Other: \_\_\_\_\_

<b>Today's Date:</b> <a href="#">Click to enter a date.</a>	<b>Facility Name:</b>
<b><i>Old Office Address</i></b>	<b><i>New Primary Office Address</i></b>
Facility Name:	Facility Name:
Address:	Address:
City:	City:
State/Zip:	State/Zip:
Telephone: Fax:	Telephone: Fax:
Email address:	Email address:
Tax ID number:	Tax ID number:
<b>Should old TIN be Terminated</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date of change: <a href="#">Click here to enter a date.</a>

<b><i>Additional Office Address (attach list if needed)</i></b>	<b><i>Mailing Office Address (if different from Primary)</i></b>
Facility Name:	Facility Name:
Address:	Address:
City:	City:
State/Zip:	State/Zip:
Telephone: Fax:	Telephone: Fax:
Email address:	Email address:
Tax ID number:	Tax ID number:
Effective date of change: <a href="#">Click to enter a date.</a>	Effective date of change: <a href="#">Click to enter a date.</a>

<b><i>Billing Office Address</i></b>	<b>Services Provided:</b>
Facility Name:	
Address:	Age Limits:
City:	Languages:
State/Zip:	Office Hours:
Telephone: Fax:	Medicare #:
Email:	Medicaid #:
Billing Manager:	NPI # :
Billing Manager Phone:	Billing Manager Email:
Effective date of change: <a href="#">Click to enter a date.</a>	
Do you bill on HCFA or UB92? (please provide copy with boxes 31, 32, 33 populated)	Web address: ( <input type="checkbox"/> Yes, link to CHP website)

### **Person Completing Form:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Email Address: \_\_\_\_\_