

N.C. DIVISION OF MEDICAL ASSISTANCE MEDICAID PROVIDER CHANGE FORM

**FOR DMA/Fiscal Agent
USE ONLY
Date keyed: _____**

Items 1 and 4 are required. (Please print) Complete other information only if there is a change.

1. Provider Information

| | |
|--|--|
| Effective Date of Change: | |
| Medicaid Provider Number (<i>One provider number per form</i>): | NPI# or Change NPI#: (please attach copy of NPPES) |
| Provider Name: | |
| Type of Provider: <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Carolina ACCESS (skip to #3) | |

2. Type of Change

| | | | |
|---|-------------------------------|---|-------------------------------|
| <input type="checkbox"/> Office (Site) Location | | <input type="checkbox"/> Billing Location | |
| Address (<i>Attach copy of new Provider Participation Agreement</i>): | | Address: | |
| City: | | City: | |
| State: | Zip Code + Plus 4 (Required): | State: | Zip Code + Plus 4 (Required): |
| Office/Site Phone: | | Billing/Mailing/Payment/Accounting Phone: | |
| Fax#: | E-mail: | E-mail: | |
| Change County to: | | | |
| <input type="checkbox"/> Add or <input type="checkbox"/> Delete Individual to/from a Group (<i>The group's name and provider number must be entered in Item 1. When adding an individual provider to your group, attach an ECS Agreement with the new individual's original signature.</i>) | | | |
| First Name, Last Name (Required) | | Individual N.C. Medicaid Provider Number (Required) | |
| <input type="checkbox"/> Change in bed capacity from ___ beds to ___ beds (<i>Attach state license reflecting bed capacity change</i>) | | | |
| <input type="checkbox"/> Change in Residential Child Care Treatment Level (<i>Attach state license and Letter of Endorsement reflecting treatment level change</i>) | | | |
| <input type="checkbox"/> CLIA Certification Renewal (<i>Attach a copy of your renewed CLIA certificate</i>) | | | |
| <input type="checkbox"/> Terminate your participation due to <input type="checkbox"/> Change of Ownership <input type="checkbox"/> Other _____ | | | |

3. Changes for Carolina ACCESS Providers only:

| |
|---|
| <input type="checkbox"/> Change CA practice provider number to: _____ Reason: |
| <input type="checkbox"/> Change in contact person's name: |
| <input type="checkbox"/> After-Hours Phone: |
| <input type="checkbox"/> Change enrollment restriction information (i.e., ages 15 and up only): |
| <input type="checkbox"/> Change enrollment limit from: _____ to: _____ |
| <input type="checkbox"/> Add counties served: |
| <input type="checkbox"/> Delete counties served: _____ <input type="checkbox"/> Other: _____ |

4. Signature

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual provider changes must have the provider's original signature. Authorized agents can only sign for a group change.

| | |
|---|--------------|
| _____ | _____ |
| Signature of Individual or Authorized Agent | Date |
| _____ | _____ |
| Printed Name | Title |
| _____ | _____ |
| | Phone Number |

To reach the CSC EVC Center, call 866-844-1113.
Mail this form to: CSC EVC Center, P.O. Box 300020, Raleigh, NC 27622-8020 or fax to 866-844-1382.