North Carolina Division of Medical Assistance
MEDICAID PROVIDER CHANGE FORM

FOR DMA USE ONLY
Date keyed: _____
Initials: _____

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 (*one provider number per form*):	NPI# or Change NPI#: (please attach copy of NPPES)
Provider Name:	
Type of Provider: ❑ Individual ❑ Group ❑ Carolina ACCESS (skip to #3)	

2. Type of Change

❑ **Office (Site) Location**		❑ **Billing Location**	
Address (*attach copy of new Provider Participation Agreement*):		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:			

❑ Add or ❑ Delete Individual to/from a Group *(The group's name and provider number must be entered in Item 1.)*

First Name, Last Name (Required)	Individual N.C. Medicaid Provider Number (Required)

❑ Change in bed capacity from ____ beds to ____ beds *(Attach state license reflecting bed capacity change)*

❑ CLIA Certification Renewal *(attach a copy of your renewed CLIA certificate)*

❑ Terminate your participation.

3. Changes for Carolina ACCESS Providers only:

❑ Change CA practice provider number to:_____
Reason:

❑ Change in contact person's name:

❑ After-Hours Phone:

❑ Change enrollment restriction information (i.e., ages 15 and up only):

❑ Change enrollment limit from: to:

❑ Add counties served:

❑ Delete counties served: ❑ 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 Division of Medical Assistance Provider Services Section call (919) 855-4050
Mail this form to: DMA Provider Services, 2501 Mail Service Center Raleigh, N.C. 27699-2501 or fax to (919) 715-8548.

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