

INSTRUCTIONS FOR COMPLETING THE MEDICAID FEE FOR SERVICE PROVIDER CHANGE OF ADDRESS FORM

General Instructions

- Pages 1 and 2 of the Change of Address Form must be returned. Red ink, white out and double-sided forms are unacceptable. This form is only for Fee for Service Providers.
- Page 1: list the Provider Number, NPI (if applicable for the provider type), Provider Name, and Category of Service.
- Page 1: list the new correspondence and pay to locations, if applicable. If no changes to these addresses, leave blank.
- Provider's original signature is required on the bottom of the first page of the form.
- Pages 1 and 2: list the begin dates for each address update.
- Page 2: list the following information:
 - old service location(s) with the word "CLOSE", if applicable
 - new service location(s) with the word "ADD", if applicable

Please see below for additional instructions based on provider type.

Durable Medical Equipment (DME)

- DME dealers must first change their service address with Medicare. Once confirmation is received from Medicare, complete the Change of Address form and submit that form with a copy of the new Medicare Award Letter showing the updated service address.

Hearing Aid Dealers/Audiologists

- Hearing Aid Dealers and Audiologists must first change their service address on their state license/registration. Once the updated license/registration is received, complete the Change of Address Form and submit that form with a copy of the current license/registration showing the new service address.

Laboratory

- Laboratories must first change their service address on their state license/registration. Once the updated license/registration is received, complete the Change of Address Form and submit that form with a copy of the current license/registration showing the new service address.

Nurse Registries

- Nurse Registries must first change their service address on their state license/registration. Once the updated license/registration is received, complete the Change of Address Form and submit that form with a copy of the current license/registration showing the new service address.

Pharmacies

- Pharmacies must first change their service address with Medicare and also on their state license/registration.
- Once confirmation is received from Medicare and the updated license is received, complete the Change of Address Form and submit that form with a copy of the new Medicare Award Letter and a copy of the current license/registration both showing the new service address.

Physicians

- If the physician has a limited license an amendment letter to the Affidavit of Agreement from the Department of Health showing the new address must accompany the Change of Address Form.
- If a physician is adding an out of state service address it must be accompanied by their license in that state.

RN/LPN Private Duty Nursing

- RN/LPNs cannot list a beneficiary address on their NYS Medicaid Provider file.
- RN/LPNs can only have one Service address and this can only be their home address. Correspondence and Pay to address may be different, as long as it is not the address of a Medicaid beneficiary.

Transportation

- Ambulance providers (COS 0601) must first change their service address with Medicare and on their state license/registration. Once the confirmation is received, complete the Change of Address form and submit that with a copy of the new Medicare Award Letter and current license/registration both showing the new address.

For questions regarding this form, please contact the eMedNY Call Center at 1 (800) 343-9000.

SERVICE ADDRESSES

Each address where you see Medicaid beneficiaries must be listed on our file. If no service address changes are necessary, leave this blank. Any addresses to be changed, closed or added should be listed below. Please write **CHANGE, CLOSE** or **ADD** next to that address and Locator number, if known. *A Service Address must be a street address and cannot be a P.O. Box.*

Begin date: :__::____::____::____::____::____:
M M D D Y Y

ATTENTION: _____

STREET: _____

CITY: _____

STATE: _____ ZIP: _____ - _____ COUNTY CODE: _____

TELEPHONE: _____

Begin date: :__::____::____::____::____::____:
M M D D Y Y

ATTENTION: _____

STREET: _____

CITY: _____

STATE: _____ ZIP: _____ - _____ COUNTY CODE: _____

TELEPHONE: _____

Begin date: :__::____::____::____::____::____:
M M D D Y Y

ATTENTION: _____

STREET: _____

CITY: _____

STATE: _____ ZIP: _____ - _____ COUNTY CODE: _____

TELEPHONE: _____

Begin date: :__::____::____::____::____::____:
M M D D Y Y

ATTENTION: _____

STREET: _____

CITY: _____

STATE: _____ ZIP: _____ - _____ COUNTY CODE: _____

TELEPHONE: _____

PHOTOCOPIES OF THIS PAGE MAY BE USED WHEN REPORTING MORE THAN 4 SERVICE ADDRESSES