

DEA UPDATE FORM

MEDICAID PROVIDER MAINTENANCE

PROVIDER NUMBER \_\_\_\_\_  
8 digit Medicaid Number (Required) 10 digit NPI (Required)

PROVIDER NAME   
NAME EXACTLY AS IT APPEARS ON YOUR LICENSE/REGISTRATION

PROVIDER CORRESPONDENCE ADDRESS

STREET - LINE 1

- LINE 2

CITY   
Do NOT use abbreviations

STATE  ZIP CODE  COUNTY

DEA NUMBER   
A copy of the DEA certificate must be attached.

I hereby request that the DEA information provided above be updated in my records.

PROVIDER'S SIGNATURE (Original Signature REQUIRED.)

AUTHORIZED REPRESENTATIVE'S SIGNATURE (Original Signature REQUIRED.)

AUTHORIZED REPRESENTATIVE'S TITLE

DATE SIGNED