

**MEDICARE INFORMATION
UPDATE FORM**

MEDICAID PROVIDER MAINTENANCE

MEDICAID

PROVIDER

NUMBER _____
8 digit Medicaid Number (Required)

10 digit NPI (Required, unless NPI exempt)

**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

MEDICARE INFORMATION

MEDICARE No.

|_|_|_|_|_|_|_|_|_|

MEDICARE CONTRACTORS

Indicate your Medicare Contractor by checking the appropriate box below.

- | | |
|--|---|
| <input type="checkbox"/> BC BS of Greater NY | <input type="checkbox"/> BC Northeastern NY |
| <input type="checkbox"/> GHI | <input type="checkbox"/> BC - Western New York |
| <input type="checkbox"/> Travelers Insurance Co. | <input type="checkbox"/> BC - Central New York |
| <input type="checkbox"/> Metropolitan Life Insurance | <input type="checkbox"/> Hospital Serv Corp - Jefferson |
| <input type="checkbox"/> BC-BS - Genesee Valley | <input type="checkbox"/> Out-of-State |
| <input type="checkbox"/> BS - Western New York | |

I hereby request that the Medicare 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