NYS MEDICAID INSTITUTIONAL/RATE BASED PROVIDER CHANGE OF ADDRESS FORM

MAIL TO: eMedNY
PO Box 4610
Rensselaer, NY 12144-4610

The New York State Department of Health, Office of Health Insurance Programs, requires all providers to notify the Medicaid Program in writing if they change their CORRESPONDENCE, PAY TO and/or CORPORATE ADDRESS(ES).

In order to ensure that your facility provider file is properly updated, it is necessary that your facility:

1. COMPLETE AND SIGN THE BELOW FORM. PLEASE PRINT CLEARLY. (Do not use red ink, nor white-out)

NOTE: This form can only be used to change the facility's CORRESPONDENCE, PAY TO and/or CORPORATE ADDRESS(ES). Changes to a facility's service addresses are based on receipt of official notification concerning changes to the provider's operating certificates and licenses or information received directly from the State Agency area responsible for this program type.

NPI #: _____ Provider # *(if NPI exempt)*: _____

Provider Name:_____
Enter the Provider name exactly as the facility / program is enrolled.

I wish to change the address to which my CORRESPONDENCE, is sent.
LOCATOR CODE 01: CORRESPONDENCE ADDRESS - Must specify a street address. **May NOT be a P.O. Box only.**

ATTENTION: _____
Use this line if you wish the mail directed to an agency name, building, department or job title ***other than the Provider name.***
Street:_____
City:_____
State:_____**ZIP:**_____**COUNTY:**_____
Telephone:_____ **E-mail address:** _____

Please send my MEDICAID CHECKS and/or REMITTANCE STATEMENTS to the address below:
LOCATOR CODE 02: PAY TO ADDRESS.

ATTENTION:_____
Follow the "Attention Line" instructions for Locator Code 01.
STREET:_____
CITY:_____
STATE:_____**ZIP:**_____**COUNTY:**_____

I wish to change the Corporate address for the FEIN associated with this Provider ID.
Please note that the corporate address should reflect the name and address as it appears on the FEIN documentation. The corporate address is the address to which corporate level correspondence and annual tax documents will be sent. This request MUST be accompanied by a copy of the entity's FEIN documentation (a W-9 form is not sufficient for this purpose).
ATTENTION:_____
STREET:_____
CITY:_____
STATE:_____**ZIP:**_____**COUNTY:**_____
Telephone:_____ **E-mail address:** _____

SIGNATURE OF PROVIDER REPRESENTATIVE:_____

PRINT NAME, TITLE & DATE: _____
A signature is **mandatory** and must be the facility's Administrator or an Authorized Representative.
It must be original and legible. A **Photocopy** or a **Stamp** is **unacceptable** for a signature.
Thank you for your cooperation and participation in the New York State Medicaid Program.