PROMISe™ OLTL Waiver Provider Change of Information Form

Instructions

This form should be used to request changes to your agency's Provider Type 59 Service Locations ONLY.

This form can be used be used for the following purposes only:

1.) To change the *Service Location* address if the agency has relocated. **(Section 1)**
2.) To change a *Mail to, Pay-To, Home Office* and/or *IRS* address for an existing service location. **(Section 1)**
3.) To change a *phone number* for an existing service location. **(Section 1)**
4.) To change the *contact information* for an existing service location. **(Section 1)**
5.) To change an *email* address for an existing service location. **(Section 1)**
6.) To *close* an existing service location. **(Section 2)**
7.) To *add* or *terminate* participation with a Provider Eligibility Program (PEP). **(Section 3)**
8.) To *add* or *terminate* a specialty code for an existing service location. **(Section 3)**
9.) To *terminate* association (fee assignment) with a Provider Group by an Individual. **(Section 4)**

This form **cannot** be used to **add** a service location. A new service location requires a complete PROMISe™ Provider Enrollment Application accompanied with any required forms. You may submit the new enrollment application at the PROMISe Enrollment Information web page located at http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994.

Note: Please remember to sign and date on the bottom of page 5.

Please return this form and supplemental documents to:

Department of Human Services
Office of Long-Term Living
Bureau of Fee for Service Programs
Division of Provider Operations
Attention: Enrollment & Certification Section
PO Box 8025
Harrisburg, PA 17105-8025

OR

Email: ra-hcbsenprov@pa.gov

OR

Fax: 717.346.1483

PROMISe™ Provider Address Change Request

If making changes to multiple service locations, copy page 2 and 3.

Section 1:

Current/Old Information (Address/Phone/Contact/Email)

The following information is what is currently listed for this service location.

Provider Name: _____

PROMISe™ Provider Number: __ __ __ __ __ __ __ __ __ __ _ - __ __ __ __

Provider Type/Description: **59 / OLTL Programs**

☐ Mail- To ☐ Pay- To ☐ Legal Entity/ Home Office ☐ Service Location

Street Address: _____

City: _____ State: _____

Zip Code: __ __ __ __ __ - __ __ __ __ County: _____

Contact Name: _____ Title: _____

Email Address: _____

Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Fax: (__ __ __) - __ __ __ - __ __ __ __

New Information (Address/Phone/Contact/Email)

The information listed below is new. Only list information that has changed from what's currently listed for this service location

Provider Name: _____

PROMISe™ Provider Number: __ __ __ __ __ __ __ __ __ __ _ - __ __ __ __

Provider Type/Description: **59 / OLTL Programs**

☐ Mail- To ☐ Pay- To ☐ Legal Entity/ Home Office ☐ Service Location

Street Address: _____

City: _____ State: _____

Zip Code: __ __ __ __ __ - __ __ __ __ County: _____

Contact Name: _____ Title: _____

Email Address: _____

Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Fax: (__ __ __) - __ __ __ - __ __ __ __

Complete the following fields to indicate if information has changed for other addresses or service locations.

☐ Mail- To ☐ Pay- To ☐ Legal Entity/ Home Office ☐ Service Location

Street Address: ______________________________

City: ____________________ State: ____________________

Zip Code: __ __ __ __ __ - __ __ __ __ County: ____________________

Contact Name: ____________________ Title: ____________________

Email Address: ______________________________

Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Fax: (__ __ __) - __ __ __ - __ __ __ __

☐ Mail- To ☐ Pay- To ☐ Legal Entity/ Home Office ☐ Service Location

Street Address: ______________________________

City: ____________________ State: ____________________

Zip Code: __ __ __ __ __ - __ __ __ __ County: ____________________

Contact Name: ____________________ Title: ____________________

Email Address: ______________________________

Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Fax: (__ __ __) - __ __ __ - __ __ __ __

☐ Mail- To ☐ Pay- To ☐ Legal Entity/ Home Office ☐ Service Location

Street Address: ______________________________

City: ____________________ State: ____________________

Zip Code: __ __ __ __ __ - __ __ __ __ County: ____________________

Contact Name: ____________________ Title: ____________________

Email Address: ______________________________

Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Fax: (__ __ __) - __ __ __ - __ __ __ __

VERIFY YOUR **IRS ADDRESS** BELOW: ***Note-*** this is the address where your agency's 1099 document will be sent. *If this address has changed, please provide a copy of the* ***IRS-generated FEIN document*** *effectuating the change.*

Street Address: _____

City: _____ State: _____

Zip Code: __ __ __ __ __ - __ __ __ __ County: _____

Contact Name: _____ Title: _____

Email Address: _____

Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Fax: (__ __ __) - __ __ __ - __ __ __ __

Section 2:

Please ***CLOSE*** the following service location on my provider file: copy this page if requesting to close more than one service location:

Provider Name: _____

PROMISe™ Provider Number: __ __ __ __ __ __ __ __ __ _ - __ __ __ __

Provider Type/Description: **59 / OLTL Programs**

Street Address: _____

City: _____ State: _____

Zip Code: __ __ __ __ __ - __ __ __ __ County: _____

Contact Name: _____ Title: _____

Email Address: _____

Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Fax: (__ __ __) - __ __ __ - __ __ __ __

Section 3:

Please add or end date the agency's participation with the following PEP OR add or end date the agency's specialty code or sub-specialty. A copy of the **Provider Enrollment Information Form**, **applicable license/certification** and **job descriptions** must accompany the agency's request

☐ Add a Provider Eligibility Program (PEP) for this provider.

☐ End-date the Provider Eligibility Program (PEP) for this provider.

☐ Add a Specialty or sub-specialty for this provider.

☐ End-date this specialty or sub-specialty for this provider.

Provider Name: _____

PROMISe™ Provider Number: __ __ __ __ __ __ __ __ __ _ - __ __ __ __

PEP Name: _____

Provider Type/ Description: **59 / OLTL Programs**

Specialty Number and Description: __ __ __ / _____

Sub-Specialty Number and Description: __ __ __ / _____

Effective Change Date: __ __ / __ __ / __ __ __ __

Section 4:

☐ End-date this provider from the Provider group.

Provider Name: _____

PROMISe™ Individual Provider Number: __ __ __ __ __ __ __ __ __ _ - __ __ __ __

Group Name: _____

PROMISe™ Group Provider Number: __ __ __ __ __ __ __ __ __ _ - __ __ __ __

Provider Type/ Description: **59 / OLTL Programs**

Effective date of withdrawal of Group participation: __ __ / __ __ / __ __ __ __

_____ _____

Signature of Authorized Representative Title

_____ _____

Print Name Date