Instructions for PROMISe™ Provider Service Location Change Request

This form can be used for the following purposes only:

1. To *close* an existing service location - PART 1
2. To change a *Mail-To*, *Pay-To*, or *Home Office* address for an existing service location - PART 2
3. To change an *IRS address* for an existing Provider ID - PART 2
4. To change an *e-mail address* for an existing service location - PART 2
5. To *terminate association (fee assignment)* with a Provider Group by an Individual - PART 3
6. To *add or terminate participation* with a Provider Eligibility Program (PEP) - PART 4
7. To *add or terminate a specialty code* for an existing service location - PART 4

This form **CANNOT** be used to add a service location. To add a service location, complete a PROMISe™ Provider Enrollment Application and any required forms. This form cannot be used to add a service location where actual recipient services are rendered.

If additional changes are required, copy pages 2 and 3 or attach sheets using identical format.

Please return this form to:

DHS OMAP Bureau of Fee-for-Service Programs
Division of Provider Enrollment
PO Box 8045
Harrisburg, PA 17105-8045

OR

Email: RA-ProvApp@pa.gov

PROMISe™ Provider Service Location Change Request

OLD ADDRESS

The following address is currently listed for this service location.

Provider Name: _____

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

Provider Type Number and Description: __ __ / _____

Specialty Number and Description: __ __ __ / _____

Effective Closure Date: ____/_____/_____

Street Address: _____

City: _____ County: _____

State: ___ ___ Zip Code: __ __ __ __ __ - __ __ __ __ Phone Number: (____) _____

PROMISe™ Provider Service Location Change Request

PART 1 **Please CLOSE the following service location on my provider file:**

Provider Name: _____

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

Provider Type Number and Description: __ __ / _____

Specialty Number and Description: __ __ __ / _____

Effective Closure Date: ____/_____/_____

Street Address: _____

City: _____ County: _____

State: ___ ___ Zip Code: __ __ __ __ __ - __ __ __ __ Phone Number: (____) _____

PART 2 **Please change the following address for a previously established service location. Remember, this can only be used to change a *Mail-To*, *Pay-To*, *Home Office*, *IRS*, or *E-mail address*. If you wish to add a service location, you must do so by submitting a Provider Enrollment Application.**

Provider Name: _____

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

Change the: Mail-To ☐ Pay-To ☐ Home Office ☐ IRS ☐ Effective Date:___/___/_____

E-mail Address: _____

Street Address: _____

City: _____ County: _____

State: ___ ___ Zip Code: ___ ___ ___ ___ ___ - ___ ___ ___ ___ Phone Number: (___)_____

Do not forget to sign and date page 3 of this form.

PART 3 **Please terminate my association/fee assignment with the following Group:**

☐ Delete this provider from the provider group. Specify the Group Provider Number:

___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___ (Must be 13 digits)

Group Name: _____

Individual's Provider Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___

Provider Type Number and Description: ___ ___ / _____

Effective date of withdrawal from Group participation: ____/____/_____

PART 4 **Please add or end date my participation with the following Provider Eligibility Program (PEP) or add or end date my specialty code or sub-specialty.**

☐ 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: _____

Provider Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___

PEP Name: _____

Provider Type and Description: ___ ___ / _____

Specialty Number and Description: ___ ___ ___ / _____

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

Effective date of change: ____/____/_____

_____ _____

Date **Print or Type Provider Name**

_____

Original Provider Signature (Signature Stamps are not Permitted)