GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

Puerto Rico Medicaid Program

Provider Information Change Request Form

Providers are responsible for ensuring that enrollment information remains current. Providers are required to notify Puerto Rico Medicaid Program (PRMP) within 30 days of any changes in enrollment information. Failure to comply with the requirements to report changes in the provider's Medicaid enrollment information could result in the termination of the provider's agreement. This requirement does not apply to provider records that are terminated or in the revalidation process.

Changes post-enrollment may only need notification to the Provider Enrollment Unit, and others may need a new enrollment application. Both are explained below.

Allowed Changes Without New Application

The following changes require notification to the Provider Enrollment Unit on the Provider Information Change Request Form with the provider's or managing employee's signature:

- Name change
- Mail-to and pay-to address changes
- Service location information changes limited to name, suffix, phone number, email address, hours of operation, accessibility, Americans with Disabilities Act (ADA) compliance, or after-hours arrangements
- Service Location Address corrections (for minor corrections only, such as spelling errors; this does not include different or new service locations)
- Clinical Laboratory Improvement Amendments (CLIA) and Drug Enforcement Administration (DEA) certificate updates
- Provider Specialty Additions/Changes – Specialty additions and changes for provider types of Physician and Dentist must be submitted with the specialty certificate (Ambulance providers require a license specific to the specialty they are adding; other provider types do not require documentation to add or change a specialty)
- Changes in Individual/Group Practice Associations – Providers must include the following information:
  - Individual provider's National Provider Identifier (NPI)
  - Group provider Medicaid ID
  - Effective date
- Gender
- Date of birth

- Language
- Medicare number
- Surety bond (with a copy of the bond)
- NPI – This is only permitted when an NPI has been found to be a subject of fraud and the provider has been issued a replacement NPI or if it was entered incorrectly
- Social Security Number (SSN) or Tax ID (only if a typo has been determined) – The W-9 must reflect the correct Tax ID

Changes Requiring New Application

The following changes require a new enrollment application completed through the PRMP Provider Enrollment Portal (PEP):

- New service location
- Enrolling as a different provider type – Providers must submit a separate Provider Enrollment Application for each provider type
- Ownership / Tax ID changes – When a provider states that there is a change of ownership or change in Tax ID, a new application must be completed; if there is simply a typo in the Tax ID or SSN, then the correction can be made to the existing active provider record as long as the provider submits the request in writing and includes a correct W-9. Examples of change in ownership include, but are not limited to, the following:
  - A sole proprietorship transfers title and property to another party
  - Two or more corporate clinics or centers consolidate, and a new corporate entity is created
  - An incorporated entity merges with another incorporated entity
  - An unincorporated entity (sole proprietorship or partnership) becomes incorporated
  - Change of name and Tax ID number associated with the provider's submitted enrollment application (e.g., Employer Identification Number)

One form is required for each individual NPI.

1. Basic provider information

Provider Name:	**Provider NPI:**

2. Name Change

Name Type	**Current Name**	**Change To**
Provider Name		
Doing Business As (DBA) Name		
Reason for Name Change		

3. Mail-to and pay-to address changes

CHECK ONE			
Mail-to Address	☐ CHANGE		
Pay-to Address	☐ CHANGE		
Effective Date *(Use date format MM/DD/YYYY):*			
Mailing Address Line 1 *(Street Name and Number)*		**Mailing Address Line 2** *(Suite, Room, etc.)*	
City		**State**	**Zip Code +4**
Telephone Number	**Email Address**		
Pay-to Address Line 1 *(Street Name and Number)*		**Pay-to Address Line 2** *(Suite, Room, etc.)*	
City		**State**	**Zip Code +4**
Telephone Number	**Email Address**		

4. Service location information changes limited to name, phone number, email address, hours of operation, accessibility, Americans with Disabilities Act (ADA) compliance, or after-hours arrangements

Name			
Service Location Address correction (This is for minor corrections only, such as spelling errors. This does not include different or new service locations.)			
Current Service Location Address		**Correct Service Location Address**	
Telephone Number		**Email Address**	
Hours of Operation			
Day of the Week	**Begin Hour**	**End Hour**	**Closed**
Monday			☐
Tuesday			☐
Wednesday			☐
Thursday			☐
Friday			☐
Saturday			☐
Sunday			☐
Accessibility			
Is the service location accessible by public transportation?		☐ Yes	☐ No
Americans with Disabilities Act (ADA) Compliance			
Is the service location ADA compliant?		☐ Yes	☐ No
After-hours Arrangements			
What are your after-hours arrangements?			

5. Clinical Laboratory Improvement Amendments (CLIA) and Drug Enforcement Administration (DEA) certificate updates

CLIA Number:		**Type:**	
Effective Date *(Use date format MM/DD/YYYY):*			
End Date *(Use date format MM/DD/YYYY):*			
DEA Number:			
Begin Date *(Use date format MM/DD/YYYY):*			
End Date *(Use date format MM/DD/YYYY):*			

6. Provider Specialty & Taxonomy Additions/Changes – Refer to the Provider Type, Specialty, Taxonomy listing; please include a copy of your license

CHECK ONE	☐ ADD	☐ DELETE
Provider Specialty (*Code*)		
Taxonomy		
Effective Date *(Use date format MM/DD/YYYY)*		

7. Changes in Group Practice Association for Individuals – Providers must include the following information:

   a. Group provider's National Provider Identifier (NPI)
   b. Approved Group provider Medicaid ID
   c. Effective date

Group NPI	**Group Medicaid ID**	**Type of Update**			**Effective Date**	**End Date**
		☐ ADD	☐ CHANGE	☐ DELETE		
		☐ ADD	☐ CHANGE	☐ DELETE		
		☐ ADD	☐ CHANGE	☐ DELETE		
		☐ ADD	☐ CHANGE	☐ DELETE		
		☐ ADD	☐ CHANGE	☐ DELETE		
		☐ ADD	☐ CHANGE	☐ DELETE		
		☐ ADD	☐ CHANGE	☐ DELETE		

8. Changes in Individual Practice Association for Groups – Providers must include the following information:

   a. Individual provider's National Provider Identifier (NPI)
   b. Approved Individual provider Medicaid ID
   c. Effective date

Individual NPI	**Individual Medicaid ID**	**Type of Update**			**Effective Date**	**End Date**
		☐ ADD	☐ CHANGE	☐ DELETE		

Individual NPI	Individual Medicaid ID	Type of Update			Effective Date	End Date
		☐ ADD	☐ CHANGE	☐ DELETE		
		☐ ADD	☐ CHANGE	☐ DELETE		
		☐ ADD	☐ CHANGE	☐ DELETE		
		☐ ADD	☐ CHANGE	☐ DELETE		
		☐ ADD	☐ CHANGE	☐ DELETE		
		☐ ADD	☐ CHANGE	☐ DELETE		

9. Additional Information

Gender	☐ Female	☐ Male
Date of Birth *(Use date format MM/DD/YYYY)*		
Language		
Medicare Number		

10. Surety Bond – Providers must include a copy of the bond

Medicaid Surety Bond Number	
Effective Date *(Use date format MM/DD/YYYY)*	
End Date *(Use date format MM/DD/YYYY)*	
Medicare Surety Bond Number	
Effective Date *(Use date format MM/DD/YYYY)*	
End Date *(Use date format MM/DD/YYYY)*	

11. NPI – This is only permitted when an NPI has been found to be a subject of fraud and the provider has been issued a replacement NPI or if it was entered incorrectly

Old NPI Number	
Effective Date *(Use date format MM/DD/YYYY)*	
End Date *(Use date format MM/DD/YYYY)*	
New NPI Number	
Effective Date *(Use date format MM/DD/YYYY)*	

12. Social Security Number (SSN) or Tax ID (only if a typo has been determined) – The W-9 must reflect the correct Tax-ID

Incorrect SSN		**Correct SSN**	
Incorrect Tax ID		**Correct Tax ID**	

By signing this document electronically, I attest that all the information provided is true and accurate, and that I will notify the PRMP of any changes to the information contained.

Signature of person authorizing this change: _____

Printed Name: _____

Date (Use date format MM/DD/YYYY): _____

Upload this form as an attachment to your Change Request form through the Provider Secure Communication (PSC) portal. Do NOT attach Protected Health Information (PHI) to your application.