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 Medicaid provider's agreement.

Some changes can be submitted via this form through the Provider Secure Communication (PSC) portal, and some require a new enrollment application.

Changes via Change Request Form (no new application required)

The following changes require notification to the Provider Enrollment & Maintenance Unit (PEMU) 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 address information changes are limited to corrections only, such as spelling or zip code errors. This does not include different or new service locations.
- Hours of operation.
- Licenses and certificate updates: ex. Clinical Laboratory Improvement Amendments (CLIA), Drug Enforcement Administration (DEA), and Controlled Substance.
- Provider Specialty/Taxonomy Additions/Changes.
- Changes in Groups/Individual within in a group; this includes additions and terminations. Providers must include the following information:
    - Individual within a Group/Group provider's National Provider Identifier (NPI)
    - Individual within a Group/Group provider's Medicaid ID
    - Effective/End date
- Gender.
- Date of Birth.
- Language.
- Medicaid Surety Bond (with a copy of the bond).
- Social Security Number (SSN) or Tax ID (only if a typo has been determined). The W-9 must reflect the correct Tax-ID.
- Managing Employee – Changes of general manager, business manager, administrator, director, or other individual who exercises operational or managerial control, or over directly or indirectly conducts the day-to-day operations of an institution, organization, or agency.
- Enrollment Terminations.

Changes Requiring a 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 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 Medicaid ID.

1. **Provider Information –** This section is required.

Provider Name	**Provider NPI**	**Medicaid ID**

2. **Provider Name Change and/or Correction**

Individual Name - *Please provide a copy of the legal document for the name change (e.g., marriage certificate, divorce decree of dissolution)*	
Current Name	
Change To	
Business Name – *Please provide an updated W9 form*	
Current Name	
Change To	
Doing Business As (DBA) Name - *Please provide an updated W9 form*	
Current Name	
Change To	
Reason for Name Change	

3. **Mail-to and pay-to address changes**. Fill out the fields for the address that needs to be changed.

Mail-to Address	☐ CHANGE	
Mail-to Address Line 1 *(Number and Street Name, or PO Box)*	**Mail-to Address Line 2** *(Suite, Room, etc.)*	
City	**State**	**Zip Code +4**

Telephone Number	**Email Address**

Pay-to Address	☐ CHANGE	
Pay-to Address Line 1 *(Number and Street Name, or PO Box)*	**Pay-to Address Line 2** *(Suite, Room, etc.)*	
City	**State**	**Zip Code +4**
Telephone Number	**Email Address**	

4. **Service Location information**

Service Location Address correction - Changes are limited to corrections only, such as spelling or zip code errors. This does not include different or new service locations. New service locations require a new application. PO Box addresses are not considered a valid service location address. Providers with Enrollment type of Individual within a Group (IG) do not have a physical service location on their record. IGs service locations are identified based on the association to group(s).		
Service Location Address Line 1 *(Number and Street Name)*	**Service Location Address Line 2** *(Suite, Room, etc.)*	
City	**State**	**Zip Code +4**
Telephone Number	**Email Address**	
Reason for Service Location address change		

5. **Hours of Operation**

Hours of Operation		
Day of Week	**From Hour***	**To Hour***
Every Day		
Monday		
Tuesday		
Wednesday		
Thursday		

Friday		
Weekdays		
Saturday		
Sunday		
Weekends		

* If 24 hours, indicate "24 Hours"

6. **Clinical Laboratory Improvement Amendments (CLIA),Drug Enforcement Administration (DEA) and Controlled Substance certificate updates.**

   Please include a copy of the certificate.

CLIA Number		**CLIA Type**	
CLIA Effective Date *(Use date format MM/DD/YYYY)*			
CLIA End Date *(Use date format MM/DD/YYYY)*			
DEA Number			
DEA Begin Date *(Use date format MM/DD/YYYY)*			
DEA End Date *(Use date format MM/DD/YYYY)*			
Controlled Substance Number		☐ Dispense	☐ Prescribe
Controlled Substance Effective Date *(Use date format MM/DD/YYYY)*			
Controlled Substance End Date *(Use date format MM/DD/YYYY)*			

7. **Provider Specialty & Taxonomy Additions/Changes** – Refer to the Provider Type, Specialty, and Taxonomy listing available on the PEP Medicaid web site.

   Please include a copy of your license/and or certificate.

Select One		**Type of Update**			**Effective Date**	**End Date**
Provider Specialty (*Code*)		☐ ADD	☐ END DATE	☐ PRIMARY		
Taxonomy *(Code)*		☐ ADD	☐ END DATE	☐ PRIMARY		

8. **Individuals within a Group (IG) to Group Practice Association** – This section is to be used for IGs who need to associate to a Group. If you have more than 7 associations to make, please use instead

of this form the Bulk Group Association Request Excel Spreadsheet, available on the PEP Medicaid website. Providers must include the following information:

a. Group provider's National Provider Identifier (NPI)
b. Group provider Medicaid ID
c. Type of Update:
    i. Add – Add a new association
    ii. Change – Change an existing association date span
    iii. End Date – Cancel/remove an existing association
d. Effective date - Effective Date of Provider Group membership in MM/DD/YYYY format
e. End date - End Date of Provider Group membership in MM/DD/YYYY format

Group NPI	Group Medicaid ID	Type of Update			Effective Date	End Date
		☐ ADD	☐ CHANGE	☐ END DATE		
		☐ ADD	☐ CHANGE	☐ END DATE		
		☐ ADD	☐ CHANGE	☐ END DATE		
		☐ ADD	☐ CHANGE	☐ END DATE		
		☐ ADD	☐ CHANGE	☐ END DATE		
		☐ ADD	☐ CHANGE	☐ END DATE		
		☐ ADD	☐ CHANGE	☐ END DATE		

9. **Group Practice Association to Individual within a Group (IG)** – This section is to be used for Groups who need to associate IGs to themselves. If you have more than 7 associations to make, please use instead of this form the Bulk Group Association Request Excel Spreadsheet, available on the PEP Medicaid website. Providers must include the following information:

a. Individual provider's National Provider Identifier (NPI)
b. Individual within a Group (IG) provider Medicaid ID
c. Type of Update
    i. Add – Add a new association
    ii. Change – Change an existing association date span
    iii. End Date – Cancel/remove an existing association
d. Effective date - Effective Date of Provider Group membership in MM/DD/YYYY format
e. End date - End Date of Provider Group membership in MM/DD/YYYY format

Individual within a Group (IG) NPI	Individual within a Group (IG) Medicaid ID	Type of Update			Effective Date	End Date
		☐ ADD	☐ CHANGE	☐ END DATE		
		☐ ADD	☐ CHANGE	☐ END DATE		
		☐ ADD	☐ CHANGE	☐ END DATE		
		☐ ADD	☐ CHANGE	☐ END DATE		
		☐ ADD	☐ CHANGE	☐ END DATE		
		☐ ADD	☐ CHANGE	☐ END DATE		
		☐ ADD	☐ CHANGE	☐ END DATE		

10. **Additional Information**

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

11. **Medicaid Surety Bond** – Providers must include a copy of the Medicaid Surety Bond

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

12. **Social Security Number (SSN) or Tax ID (only if a typo has been determined)** – Please include a signed W-9 that reflects the correct SSN or Tax-ID.

Incorrect SSN		**Correct SSN**	
Incorrect Tax ID		**Correct Tax ID**	
Reason for SSN/Tax ID Change			

13. **Managing Employee** – Changes of general manager, business manager, administrator, director, or other individual who exercises operational or managerial control, or over directly or indirectly conducts the day-to-day operations of an institution, organization, or agency. **To change the Managing Employee, please complete Appendix A: Managing Employee Form.**

14. **Enrollment Terminations –** Providers must notify Medicaid in writing 30 days in advance of their request date to terminate their enrollment. For change of ownerships (CHOW), include supporting documentation, such as bill of sale in which the change took place.

Provider Name			
Medicaid ID			
NPI			
Type of Termination	**Check all that apply**		
	☐ BUSINESS CLOSURE	☐ CHANGE OF OWNERSHIP	☐ VOLUNTARY TERMINATION
Detailed explanation of Termination			
Effective Date *(Use date format MM/DD/YYYY)*			

Authorized Signature

By signing this document electronically, I attest that I am authorized to make this change and 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 the person that is authorized to make this change**

Electronic signatures are allowed. Typed name is not acceptable as a signature.

_____ _____

Title ***Printed Name**

_____

Date *(Use date format MM/DD/YYYY)

Required fields (*)

Please provide the following contact information in the event we need to contact you regarding your request:

Contact Person Name: _____

Phone number: _____

E-mail address: _____

Upload this form through the Provider Secure Communication (PSC) portal. Do NOT include Protected Health Information (PHI).