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

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

9/1/2017
PROMISe™ Provider Service Location Change Request

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: (____) ________________

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.

9/1/2017
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: ___/___/_______

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)

9/1/2017