Instructions for PROMISe™ Provider Service Location Change Request

This form can be used for the following purposes only:

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

**Please complete old address information**

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 INFORMATION *Required*
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 Date: ___ / ___ / ________ |
| Street Address: ____________________________________________________________ |
| City: ____________________________ County: ________________________________ |
| State: ___ Zip Code: ___ ___ ___ - ___ ___ ___ Phone Number: (___) ___________ |
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: (____) ________________

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.

PART 2  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.

6/7/2018
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)