GEORGIA COLLABORATIVE ASO
Change of Information Form

This form is used to make modifications to provider information maintained by the Georgia Collaborative ASO (Collaborative) for the Department of Behavioral Health and Developmental Disabilities (DBHDD) provider system. This form should only be completed by approved DBHDD providers.

A Georgia Collaborative Change of Information Form must be completed for each Medicaid Provider ID and/or Payee Provider ID approved with DBHDD. This form CANNOT be used for a Change of Ownership.

Definitions

Medicaid Provider Number
A unique identifier issued by the Department of Community Health (DCH) for each service location.

Medicaid Payee Provider ID
A unique identifier issued by DCH for the agency's payment and remittance activity.

Medicaid Payee ID Address *(on file with DCH)*
The address where payment and remittance correspondence is sent. This address is linked to the Medicaid Payee Provider ID and must correspond to the address listed on the agency's W-9 Form.

Mailing Address
The address where the agency's mail/correspondence is sent. A Post Office Box **is** acceptable as the mailing address.

Service Location (Physical Address)
The address where services are delivered. A Post Office Box **is NOT** acceptable as the physical service location address.

Instructions

Type of Change: Select the type of change being requested.

Current Information: Complete the applicable section for the type of change selected with information currently on file with DBHDD/ASO. If a section does not apply, enter N/A.

New Information: Complete this section with new agency information, as applicable. If a section does not apply, enter N/A. See required documentation table below for information on supporting documentation.

Accreditation and Insurance: Complete this section with current accreditation and insurance information. See required documentation table below for insurance requirements.

Effective Date of Change(s)
Report the date on which all listed changes are effective.

Agency Point of Contact: Complete this section with contact information for the agency point of contact. This person will be contacted if additional information is needed to process this request.

Attestation Statement
Sign and date this form attesting to the accuracy of the requested changes. An authorized representative of the agency must sign this form to confirm the requested change(s).

NOTE: A site visit is required for all BH service locations and IDD residential services (*CRA and Respite Services*).

Return this form and any required documentation to the Georgia Collaborative via e-mail at GA_enrollment@beaconhealthoptions.com or mail to:
GA Collaborative Enrollment
P.O. Box 56324
Atlanta, Georgia 30343

The Georgia Collaborative ASO

Required Documentation Table	
Documentation Required for All Requests	
Certificate of Insurance	DBHDD requires providers to submit a certificate of insurance demonstrating the following types of insurance coverage: A. **Commercial General Liability Policy**: The Commercial General Liability Policy shall have dollar limits of $1,000,000 per incident and an annual aggregate limit of $3,000,000.00. B. **Business Auto Policy:** The Business Auto Policy shall include but not be limited to liability coverage on any owned, non-owned and hired vehicle used by Provider or Provider's personnel in the performance of services approved by DBHDD. C. **Workers Compensation Insurance:** The Workers Compensation Policy shall include coverage in the amounts of the statutory limits established by the General Assembly of the State of Georgia O.C.G.A. Section 33-9-40.1. D. **Commercial Umbrella Policy**: The Commercial Umbrella Policy must provide the same or broader coverage than those provided for in the above Commercial General Liability and Business Auto Policies. Each service location must be listed on the certificate. The certificate holder listed on the insurance certificate must be: **The State of Georgia** **Department of Behavioral Health & Developmental Disabilities** **Office of Provider Enrollment** **2 Peachtree Street NW, Suite 23-247** **Atlanta, GA 30303**
Accreditation/DBHDD Certification of Compliance	• Current Accreditation Certificate/Award Letter

Documentation Required Based on Type of Change Requested	
Section	**Type of Change**
1	**Agency Name Change** • Documentation from the IRS reflecting new agency legal name and existing Tax ID on file with DBHDD/ASO *(IRS Form 147-C or CP575-A)* • Georgia Secretary of State Registration reflecting new agency legal name • Form W-9 reflecting new agency name and/or address **Individual Name Change** • Social Security Card reflecting new name • Copy of Professional License reflecting new name *(if applicable)* • Form W-9 reflecting new individual name and/or address **Tradename/DBA Change** • **Tradename Registration:** "DBA" or trade name Registration filed with the Clerk of the Superior Court of the county of the organization's domicile. The documentation should display the stamp of the Clerk of Superior Court showing the date on which the Registration was filed and the Clerk's recording information. For more information see Georgia Code O.C.G.A. 10-1-490.
2	**Medicaid Payee Id Address Change** • Form W9 reflecting new payee address.
3, 4	**Corporate Address Change** • **Georgia Secretary of State Registration:** Documentation from the Georgia Secretary of State reflecting new corporate address
5	**Service Location Physical Address Change** • **Business License:** A current Business License for all service locations (excluding Individual IDD providers, PHC/CLA and Host Home Sites) reflecting the new address. *If a business license is not required by the municipality, documentation of the exemption must be provided from the municipality.* • **Healthcare Facility Regulation Division (HFRD) License/Permit:** A current HFRD License/Permit reflecting the new address (as applicable): o **Drug Abuse Treatment and Education Program (DATEP) permit:** Non-Intensive Outpatient (Core Benefit) package and Substance Abuse specialty services o **Narcotics Treatment Program (NTP):** Medication Assisted Treatment services o **Community Living Arrangement (CLA):** Community Residential Alternative and/or Nursing Services o **Personal Care Home (PCH)**: Respite Services o **Private Home Care (PHC):** Nursing Services, Respite Services and Community Living Support Services

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Instructions: Select the type of change being requested and complete the corresponding sections for current information on file with DBHDD/ASO and new information. Refer to the Required Documentation table for additional information that must be submitted for each type of change. **Note, only one form can be used per Medicaid ID.** Duplicate this page as needed. This form CANNOT be used for a Change of Ownership.

Agency Information Changes

☐ Agency Legal Name/Individual Provider Legal Name ☐ Agency Tradename/DBA

Address Changes *Select the appropriate type of address changes below. (Check All That Apply)*

Medicaid Payee ID Information	Corporate Location Information	Georgia Corporate/ Main Location Information	Service Location Information
☐ Payee Provider ID Address ***Medicaid Payee Provider ID:***	*(If Corporate Location is Out of Georgia)* ☐ Physical Address ☐ Mailing Address	*(If Corporate Location is in Georgia)* ☐ Physical Address ☐ Mailing Address **If this is also a service location, complete the corresponding sections for service location information.*	☐ Physical Address ☐ Mailing Address ***Service Location Medicaid Provider ID:***

1A. Current Provider Information on file with DBHDD/ASO *(Required)*

Agency Legal Name/Individual Legal Name:	
ASO Provider ID:	GAC_____
Agency Tradename/DBA:	
Taxpayer ID:	

1B. New Provider Information

Agency Legal Name/ Individual Legal Name:	
Agency Tradename/DBA:	

2A. Current Medicaid Payee ID Information

Medicaid Payee ID Address:	

2B. New Medicaid Payee ID Information

Medicaid Payee ID Address:	

3A. Current Corporate Location Information on file with DBHDD/ASO

Corporate Physical Address:	
Corporate Mailing Address *(if different)*:	
Corporate Phone#:	

3B. New Corporate Location Information

Corporate Physical Address:	
Corporate Mailing Address *(if different)*:	
Corporate Phone#:	

4A. Current Ga Corporate/Main Location Information on file with DBHDD/ASO

GA Corporate Physical Address:	
GA Corporate Mailing Address *(if different)*:	
GA Corporate Phone#:	

4B. New Ga Corporate/Main Location Information

GA Corporate Physical Address:	
GA Corporate Mailing Address *(if different)*:	
GA Corporate Phone#:	

5A. Current Service Location Information on file with DBHDD/ASO

ASO Vendor Id:	
Is this a Host Home Location?	☐ Yes ☐ No
Host Home Provider Name *(if applicable)*	
Service Location Name:	
Service Location Physical Address:	
Service Location Mailing Address *(if different)*:	
Service Location Phone#:	

5B. New Service Location Information

Host Home Provider Name *(if applicable)*	
Service Location Name:	
Service Location Physical Address:	
Service Location Mailing Address *(if different)*:	
Service Location Phone#:	
Select License Type:	☐ Community Living Arrangement (CLA) ☐ Personal Care Home (PCH) ☐ Private Home Care (PHC) ☐ Drug Abuse Treatment & Education Program (DATEP) ☐ Narcotics Treatment Program (NTP)

I. Accreditation/Certification and Insurance

Attach a current Certificate of Insurance and evidence of current agency accreditation with new address if applicable. Refer to the instruction cover page for insurance and accreditation requirements.

Accreditation Information			
Accrediting Body:	☐ CARF ☐ ACHC ☐ TJC ☐ CHAP ☐ CQL ☐ DBHDD Certificate of Compliance ☐ COA	**Accreditation Expiration Date:**	
Insurance Information			
Insurance Expiration Date:			

II. Effective Date of Change

Complete this section with the date the requested changes are effective.

Effective Date	
These changes are effective as of (MM/DD/YY):	

III. Agency Point of Contact

Complete this section with contact information for the authorized representative overseeing this change of information request. This person will be contacted if additional information is needed to process this request.

Agency Point of Contact Information			
Authorized Representative's Name		**Title**	
Authorized Representative's E-mail Address		**Phone Number**:	

IV. Attestation Statement

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of material information may subject me to liability under civil and criminal law.

Authorized Representative's Name (print):_____ **Title**: _____

Authorized Representative's Signature: _____ **Date**: _____