Document Type: 4119

MEDICAID/PEACHCARE FOR KIDS PROVIDER/PAYEE ID#/REVALIDATION
Change of Information Form
Instructions for the Change of Information Form

This form is used to make modifications to Provider and Payee information maintained in the Georgia Medicaid/PeachCare for Kids (M/PCK) provider system. Only one Provider or Payee number may be modified per form. Please complete the section pertaining to your request. This form **CANNOT** be used for a Change of Ownership. **A Change of Ownership requires that a new application for enrollment be submitted.**

Check the type of change being reported

1. Enter the Georgia Medicaid/PeachCare for Kids Provider or Payee Number for which changes are being made. If you are requesting a change for more than one ID, such as multiple locations (B, C, D, etc.) separate forms are required, each reflecting a single Provider or Payee ID.

2. Medicaid Provider Number or Payee Number Deactivation Information. If the provider wishes to deactivate their M/PCK program billing number or participation in a particular M/PCK program, provide the category of service description and the reason for deactivation. This form cannot be used to deactivate GBHC participation, COS 850. If you are wishing to terminate a Payee ID, list the Payee ID here and the reason for deactivation.

3. Current Provider Identification (Required). List the provider or payee's full name or business name as it is currently on file with Georgia M/PCK. Enter the provider's social security and/or Tax Identification number as applicable.

4. New Business/Name Information. If the provider is reporting a name change, complete applicable changes to the individual, organization or group, or Payee name in the appropriate section. For any name change the provider must submit a copy of the legal document(s) (business license, license, permit, etc) showing the new name. For a change of payee name, the provider must submit an amended W-9 and official correspondence from the IRS such as Form 147-C or CP575 showing the new name and tax identification number related to the new name.

5. Office Manager Information
5a. Enter the Office Manager's Information to REMOVE from the Provider File.
5b. Enter the Office Manager's Information to ADD to the Provider File.

6. New Address/Telephone Number Information. Check "Service Location Address" if the provider has moved to a new physical location. This form is only to be used in situations in which a provider or an entire provider group moves their practice from one location to another location and the Tax ID remains the same. A copy of their IRS Form W-9 must be submitted with the completed Change of Information form. A provider who leaves one location and goes to work at another location must submit an Additional Location application.

Check "Mailing Address" if the provider would like correspondence to go to an address other than the mailing address that is currently on file. A Post Office Box **is** acceptable as the mailing address. Check "Payee Address" if the provider would like payments to go to an address other than the payee address that is currently on file. A Post Office Box **is** acceptable as the payee address. A change in payee address must be accompanied by a W-9.

7. Effective Date of Change(s) (Required). Report the date on which all listed changes are to be made effective.

8. Attestation Statement (Required). Sign and date this form attesting to the accuracy of the requested changes. If changes are being reported on an individual provider, then that individual must sign this form. If the changes are being reported for an organization or group practice, an authorized representative of the organization or group practice must sign this form to confirm the requested change(s). If you do not see the fields available for your requested change, please submit a written request for the Changes you wish to make to your Provider or Payee information on your letterhead, signed by the Provider or Authorized Representative. If you have any questions regarding this form or enrollment requirements, please contact the HP Enterprise Services Provider Enrollment Unit at (800) 766-4456. Return this form with any necessary attachments to:

HP Enterprise Services
Provider Enrollment
Fax#-1-866-483-1045

Rev. 03/2015

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GEORGIA MEDICAID/PEACHCARE FOR KIDS
PROVIDER/PAYEE ID#/REVALIDATION
Change of Information Form

Type of Change (Check all that apply)			
	☐ Medicare Information	☐ Legal Name	☐ Office Manager Information
	☐ Address Information	☐ Payee Name	☐ Deactivation of Participation
	☐ Telephone Number	☐ Taxpayer I.D.	☐ Other -Attach written request

1. Medicaid/PeachCare for Kids Provider or Payee Number: (One Provider or Payee Number per Form)

2. Deactivation of Medicaid Provider Number or Payee Number:

Medicaid Provider Number	Reason for Deactivation (Attach additional sheets if necessary)

3. Current Provider Identification (Required)

First Name:	M.I.	Last Name:	Jr., Sr., etc.	MD, DO, etc.

Business Name:

Social Security No. (if applicable)	Taxpayer ID No. (attach W-9)	NPI No.

4A. New Business / Name Information

First Name:	M.I.	Last Name:	Jr., Sr., etc.	MD, DO, etc.

Doing Business As Name (DBA):

Social Security No. (if applicable)	Taxpayer ID No. (attach W-9)	Medicare Provider No. (Attach Medicare approval letter)

B. Organizations or Entities Only

New Legal Business Name:	D/B/A Name:

C. Payee Name:	Taxpayer ID No. (attach W-9)

5A. Office Manager Information (Remove)

First Name:	Last Name:	M.I.

Social Security No.	Date of Birth:	Telephone No.:

5B. Office Manager Information (Add)

First Name:	Last Name:	M.I.

Social Security No.	Date of Birth:	Telephone No.:

6. New Address / Telephone Number

☐ Service Location Address (See Instructions) ☐ Mailing Address (PO Box is Acceptable) ☐ Pay-To Address (PB Box is Acceptable) **Attach amended W-9**

New Address Line 1:

New Address Line 2:

New City:	New State:	New Zip Code & 4	New County

New Email Address:	New Web Address:

New Telephone No.	New Fax No.:	New After Hours Telephone No.: (GBHC providers should attach)

7. Requested Effective Date of Change(s) (Required)	This change /these changes are effective as of (MM/DD/YYYY)

8. Attestation Statement (Required)

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.

Printed Name of Provider or Authorized Representative	Title:
Signature of Provider or Authorized Representative	Date: