Facility Change of Address Form

Please list **ALL New/Current addresses** in addition to any addresses we should delete from our files. Provider #:

|  |  |  |
| --- | --- | --- |
| Facility Name: | | State: |
| E-Mail Address: | Primary Contact: | |

1. \*All addresses listed below must correspond to the Tax Identification Number (TIN) listed. **If you have more than one TIN, please complete a separate address change form for each TIN currently in use.**

\*The TIN indicated below is a TIN currently in use New TIN (Please complete a W-9 form)

# TIN Owner Name

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |

(Must match W-9):

**Please complete separate forms for multiple Service Addresses. *NEW Service Locations require a Service Location Addendum.***

1. **DELETE** this Service Address: Effective Date (Required) **3 ADD/KEEP** this Service Address: Effective Date (Required)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| (Referrals) |  | / / (Referrals) | |  |  | / / |  |
| Street Address/Suite |  | Street Address/Suite (No PO Box) | |  |  |  |  |
| City State |  | Zip City State | |  |  | Zip |  |
| Phone ( ) Fax ( |  | ) Phone ( ) Fax ( Handicapped accessible Y / N Public Transportation | | | )  accessible Y/ N | |  |
| **4 DELETE** this Service Address: Effective Date (Required) **5 ADD/KEEP** this Service Address: Effective Date (Required) | | | | | | | |
| (Referrals) |  | / / (Referrals) | |  |  | / / |  |
| Street Address/Suite |  | Street Address/Suite (No PO Box) | |  |  |  |  |
| City State |  | Zip City State | |  |  | Zip |  |
| Phone ( ) Fax ( |  | ) Phone ( ) Fax ( Handicapped accessible Y / N Public Transpo | | )  rtation | | accessible Y/ | N |
| **6 DELETE** this Mailing Address: Effective Date (Required) **7 ADD/KEEP** this Mailing Address: Effective Date (Required) | | | | | | | |
| (Certification Letters) | / | / | (Certification Letters) | / | / | | |
| Street Address/Suite |  |  | Street Address/Suite |  |  | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City | State | Zip |  | City | State Zip |
| Phone ( | ) Fax ( | ) |  | Phone ( | ) Fax ( ) |

E-Mail Address: E-Mail Address:

**8 DELETE** this PayTo Address: Effective Date (Required) **9 ADD/KEEP** this PayTo Address: Effective Date (Required) (Payment) / / (Payment) / /

Street Address/Suite Street Address/Suite (No PO Box)

City State Zip City State Zip Phone ( ) Fax ( ) Phone ( ) Fax ( )

# **10** Provider Signature (Required): Date:

Fax completed form to: (866) 497‐9265 or mail to Carelon Behavioral Health PO Box 989 Latham, NY 12110. For questions please call (800)‐397‐1630.

**Address updates can be completed online via ProviderConnect.**