Instructions for PROMISe™ Provider Practice Relocation Request

This form can ONLY be used for the following Provider Types:

05- Home Health Agencies	06-Hospice
09- CRNP*	10-Midlevel Practitioners
14- Podiatrist	15-Chiropractor
16-Nurse	17-Therapist
18-Optometrist	19-Psychologist
20-Audiologist	23-Nutritionist
27-Dentist	31-Physician
32-CRNA	33-CNM

*** Provider type 05 and 06: CMS must have completed your address change in the PECOS system before you submit this form to provider enrollment**

****Provider type 09: You MUST provide a collaborative practice agreement reflecting change of address.**

All sections must be completed in full; if left blank, application will be rejected.

This form MAY be used for the following purposes only:

1. To update your ***Service Location*** address if the practice has ***relocated*** (please refer to example below).

   Example of when to use this form: The practice was located at 200 West Mills Street. The practice closed at 200 West Mills Street completely and relocated to 35 East Main Street.

2. To change a ***Mail-To*** address in conjunction with the relocation.
3. To change a ***Pay-To*** address in conjunction with the relocation.
4. To change a ***Home Office*** address in conjunction with the relocation.

This form CANNOT to be used to ADD an address or make changes to a current service location:

1. To update your ***Service Location*** address if you changed employers (please refer to example below). **Example of when NOT to use this form:** If you were employed with a practice at 100 Fairfield Drive and you left this employer and are now working for a new employer at 4350 Fowler Street.
2. If this is your situation, you **MUST** do the following:
   a) Submit a completed Provider Enrollment Application and any required related forms to add the new address: http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994

   b) Submit a **Provider Service Location Change Request to close the old address** **http://www.dhs.state.pa.us/cs/groups/public/documents/form/s_001983.pdf**

Please submit these requests to:

DHS Provider Enrollment
PO Box 8045
Harrisburg, PA 17105-8045
Fax: (717) 265-8284
Email: RA-ProvApp@pa.gov

PROMISe™ Provider Practice Relocation Request

THIS FORM CANNOT BE USED TO ADD A NEW SERVICE LOCATION OR MAKE CHANGES TO A CURRENT SERVICE LOCATION.

This form can only be used to:

- Update the Service Location address if the practice has ***RELOCATED***. **See example on instruction sheet**.
- Change the Pay-To, Mail-To, and/or Home Office address in conjunction with the relocation.

Please note: **You must complete a new Provider Enrollment Application to add a new service location where actual recipient services are provided.**

Old Address:

The following address is the address listed currently for this service location:

Provider Name: _____

PROMISe™ Provider Number: _____ ___ ___ ___ ___ ___ ___ ___ ___ _____**(13 digits)**

Provider Type Number and Description: / _____

Specialty Number and Description: / ___

Street Address: _____

City:_____County: _____

State: Zip Code:_____-_____

New Address:

The address listed below is the address of the service location now:

Provider Name: _____

Street Address:_____Room/Suite:_____

City: _____ State: _____ Zip Code:_____-_____

Phone No.: (_____)_____ County: _____

Fax No.: (_____)_____ Effective Change Date:_____/_____/_____

(1) Does the office have exterior or interior steps leading to the main entrance doorway?
Yes ☐ No ☐ Exterior ☐ Interior ☐

(2) If the answer to (1) is yes, does the office have a permanent or portable wheelchair ramp?
Yes ☐ No ☐ Permanent ☐ Portable ☐

(3) If the answer to (1) is yes, is there an alternate entrance that has no exterior or interior steps or has a wheelchair ramp?
Yes ☐ No ☐
No exterior steps ☐ No interior steps ☐
Permanent ramp ☐ Portable ramp ☐

Is this address an active Rural Health Clinic or FQHC? ☐ **Yes** ☐ **No**

Do you bill for a mobile unit from this location? ☐ **Yes** ☐ **No**
Mobile Medical Unit? ☐ Yes ☐ No
Mobile Dental Unit? ☐ Yes ☐ No

Check this block only if you wish your Medicare claims to crossover to this service location. ☐

***Once enrolled, you can retrieve RAs from PROMISe™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.

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Please complete to change the Mail-to, Pay-to and/or Home Office address for the new location.

Change the Current: Mail-To ☐ Pay-To ☐ Home Office ☐ Effective Change Date:_____/_____/_____

Address:_____Room/Suite:_____

City:_____ Email: _____

State:_____ Zip Code:_____-_____

Phone No.: (_____)_____ Fax No.: (_____)_____

Change the Current: Mail-To ☐ Pay-To ☐ Home Office ☐ Effective Change Date:_____/_____/_____

Address:_____Room/Suite:_____

City:_____ Email: _____

State:_____ Zip Code:_____-_____

Phone No.: (_____)_____ Fax No.: (_____)_____

Change the Current: Mail-To ☐ Pay-To ☐ Home Office ☐ Effective Change Date:_____/_____/_____

Address:_____Room/Suite:_____

City:_____ Email: _____

State:_____ Zip Code:_____-_____

Phone No.: (_____)_____ Fax No.: (_____)_____

Verify your **IRS Address** below: **Note**: This is the address where your **1099 tax document** will be sent.

Address:_____Room/Suite:_____

City: _____ State: _____ Zip:_____-_____

Email: _____

Phone No.: (_____)_____ Fax No.: (_____)_____

Contact Name/Phone number (should we have questions regarding your request):

Name:_____Phone Number: (_____)_____

Please **sign and date** form below:

_____ _____

Date Print or Type Provider Name

_____

Original Provider Signature (Signature Stamps Not Accepted)