Provider Address Change Form

Provider Name _____
(please print)

Provider ID Number/Taxonomy Code _____

Physical Address _____
(Where services are provided)

_____
(Post office box allowed ONLY as an addition to a street address)

_____
City **State** **ZIP+4**

_____
County **Phone Number** (Include area code)

Mailing/Billing Address _____

_____

_____
City **State** **ZIP+4**

_____
Phone Number (Include area code)

E-mail Address _____

Note: Before a change can be made in your provider file, we must have your original signature. A photo copied or stamped signature is unacceptable and the only signature valid for an individual practitioner is their own.

Provider's Signature _____ **Date** _____

Mail this completed form to:

Medicaid Provider Enrollment Unit
Hewlett Packard Enterprise
P.O. Box 8105
Little Rock, AR 72203-8105