# Change of Address Form Instructions

## Signature

- The individual provider's signature is required for all changes requested for an individual provider number.
- Signature of the authorized representative for the group/facility is required for changes to group/facility provider numbers.

## General

- Incomplete forms will be returned to the provider.
- If you have any questions, please contact ACS Provider Enrollment at (800) 884-3222.

# CHANGE OF ADDRESS FORM

Mail the completed form to: **Mississippi Medicaid Provider Enrollment**
P.O. Box 23078
Jackson, Mississippi 39225
or Fax to: (601) 206-3015

## Provider Information

Provider Name:

National Provider Identifier (NPI):

MS Medicaid Provider Number:

## Contact Information

Contact Name: Phone Number:

Email Address:

## Change of Address Information

*Please check the appropriate box below for the address type you wish to change.*

| | | |
|---|---|---|
| ☐ Servicing Address | | Street Address<br>City County State Zip Code<br>Phone Number Fax Number |
| ☐ Billing Address | | Street Address<br>City County State Zip Code |
| ☐ Mail Other Address | | Street Address<br>City County State Zip Code |
| ☐ Remittance Advice Address | | Street Address<br>City County State Zip Code |
| ☐ 1099 Mailing Address | *W-9 Required | Street Address<br>City County State Zip Code |

**Please note that providers who wish to change the 1099 Mailing Address MUST submit a copy of the W-9 Form along with this form.*

| | | |
|---|---|---|
| ☐ **All Addresses** | *W-9 Required | Street Address<br>City County State Zip Code |

## Authorization for Change

I declare under penalty of perjury under the laws of the State of Mississippi that the information in this document and any attachments are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the aforesaid Provider. I understand that Mississippi Medicaid Provider Enrollment will use the information in this document and its attachments to change my provider file.

## Provider/ Authorized Representative (Please Print Name)

**Signature** **Date**

Revised 8/25/2010