MAP-529
(REV 5/16)

Kentucky Medicaid Change of Information Form

Current Existing Information

Provider Name: ____

For an Individual, list Last Name, First Name, Middle. For an Entity/Group, list complete business name & DBA

Provider Number: ______________________ **NPI:** ______________________

Contact Name: ____

Contact Telephone: ______________________________

Email: ____

Contact Information for form preparer, credentialer or provider

Name Change Section

List Only New Information

Name Change to: ____

Reason for Name Change: ____

Required Supporting Documentation: *if applicable*

Group/Entity

__ New IRS Verification
__New CLIA
__New Medicare
__ New Accreditation
__New JCAHO
__New HME
__New Facility License

Individual

__New Social Security Card
__ New Medical License

Change of Address Section

List Only New Location Information

Physical

Street: ____
City: ____
State: __________ **Zip:** ______________
Phone: ______________________ **Fax:** ______________________

Correspondence

Street: ____
City: ____
State: __________ **Zip:** ______________
Phone: ______________________ **Fax:** ______________________

Pay-To

Street: ____
City: ____
State: __________ **Zip:** ______________
Phone: ______________________ **Fax:** ______________________

See 1099 box, next page

Return To: Kentucky Medicaid, PO Box 2110, Frankfort, KY 40602-2110, P: 877-838-5085

1099	**Street:** ____________________
	City: ____________________
	State: ________ **Zip:** ____________
	Phone: ____________________ **Fax:** ____________________

Additional Location Section *List Only New Location Information*	
Physical Address	**Street:** ____________________
	City: ____________________
	State: ________ **Zip:** ____________
	Phone: ____________________ **Fax:** ____________________
Physical Address	**Street:** ____________________
	City: ____________________
	State: ________ **Zip:** ____________
	Phone: ____________________ **Fax:** ____________________

Change to Contact Information *List Only New Information*
Contact Name:____________________
Contact Telephone:____________________
Email: ____________________
Contact Information for form preparer, credentialer or provider

Request To Terminate Kentucky Medicaid Number
I, ______________________________**, request to terminate my contract with** *Name* **Kentucky Medicaid, effective** ____________________**.** *End Date* **Medicaid Number that I am terminating:** ____________________

I authorize Kentucky Medicaid to change the current information on file to the information indicated on this form. For an individual, the individual provider's signature is required.

Printed Name: ______________________________ **Title:** ____________________

Provider Signature: ______________________________ **Date:** ____________________