

## Instructions for PROMISe™ Provider Service Location Change Request

This form can be used for the following purposes only:

- To *close* an existing service location - **PART 1**
- To change a *Mail-To, Pay-To, or Home Office* address for an existing service location - **PART 2**
- To change an *IRS address* for an existing Provider ID - **PART 2**
- To change an *e-mail address* for an existing service location - **PART 2**
- To *terminate association (fee assignment)* with a Provider Group by an Individual - **PART 3**
- To *add or terminate participation* with a Provider Eligibility Program (PEP) - **PART 4**
- To *add or terminate a specialty code* for an existing service location - **PART 4**

**\*\*Please complete old address information**

This form **CANNOT** be used to add a service location. To add a service location, complete a PROMISe™ Provider Enrollment Application and any required forms. This form cannot be used to add a service location where actual recipient services are rendered.

If additional changes are required, copy pages 2 and 3 or attach sheets using identical format.

### **Please return this form to:**

DHS OMAP Bureau of Fee-for-Service Programs  
Division of Provider Enrollment  
PO Box 8045  
Harrisburg, PA 17105-8045

OR

Email: RA-ProvApp@pa.gov

## PROMISe™ Provider Service Location Change Request

### **OLD ADDRESS INFORMATION** \*Required

The following address is currently listed for this service location.

Provider Name: \_\_\_\_\_

PROMISe™ Provider Number: \_\_\_\_\_ - \_\_\_\_\_

Provider Type Number and Description: \_\_\_\_ / \_\_\_\_\_

Specialty Number and Description: \_\_\_\_ / \_\_\_\_\_

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_ Zip Code: \_\_\_\_\_ - \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

## PROMISE™ Provider Service Location Change Request

**PART 1** Please CLOSE the following service location on my provider file:

Provider Name: _____
PROMISE™ Provider Number: _____ - _____
Provider Type Number and Description: ____ / _____
Specialty Number and Description: ____ / _____
Effective Closure Date: ____/____/____
Street Address: _____
City: _____ County: _____
State: ____ Zip Code: _____ - _____ Phone Number: (____) _____

**PART 2** Please change the following address for a previously established service location. Remember, this can only be used to change a *Mail-To, Pay-To, Home Office, IRS, or E-mail address*. If you wish to add a service location, you must do so by submitting a Provider Enrollment Application.

Provider Name: _____
PROMISE™ Provider Number: _____ - _____
Change the:    Mail-To <input type="checkbox"/> Pay-To <input type="checkbox"/> Home Office <input type="checkbox"/> IRS <input type="checkbox"/> Effective Date: ____/____/____
E-mail Address: _____
Street Address: _____
City: _____ County: _____
State: ____ Zip Code: _____ - _____ Phone Number: (____) _____

**Do not forget to sign and date page 3 of this form.**

**PART 3 Please terminate my association/fee assignment with the following Group:**

Delete this provider from the provider group. Specify the Group Provider Number:

\_\_\_\_\_ - \_\_\_\_\_ (Must be 13 digits)

Group Name: \_\_\_\_\_

Individual's Provider Number: \_\_\_\_\_ - \_\_\_\_\_

Provider Type Number and Description: \_\_\_\_ / \_\_\_\_\_

Effective date of withdrawal from Group participation: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**PART 4 Please add or end date my participation with the following Provider Eligibility Program (PEP) or add or end date my specialty code or sub-specialty.**

Add a Provider Eligibility Program (PEP) for this provider.

End-date the Provider Eligibility Program (PEP) for this provider.

Add a specialty or sub-specialty for this provider.

End-date this specialty or sub-specialty for this provider.

Provider Name: \_\_\_\_\_

Provider Number: \_\_\_\_\_ - \_\_\_\_\_

PEP Name: \_\_\_\_\_

Provider Type and Description: \_\_\_\_ / \_\_\_\_\_

Specialty Number and Description: \_\_\_\_ / \_\_\_\_\_

Sub-Specialty Number and Description: \_\_\_\_ / \_\_\_\_\_

Effective date of change: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print or Type Provider Name**

\_\_\_\_\_  
**Original Provider Signature (Signature Stamps are not Permitted)**