OMB Approval No. 0938-0685

MEDICARE AND OTHER FEDERAL HEALTH CARE PROGRAMS PROVIDER/SUPPLIER FORM CHANGE OF INFORMATION INSTRUCTIONS

Change of Information Form-HCFA 855C

Upon completion, return this form and all necessary documentation to:

MEDICARE REGISTRATION
P O BOX 44021
JACKSONVILLE, FLORIDA 32231-4021

General

This form is for reporting changes in provider/supplier information for Medicare or any other federal health care programs. All changes must be requested in writing and have an original signature. Faxed or photocopied signatures will not be accepted. Changes on this form are those made most frequently and may also be reported using HCFA Form 855, 855R, or 855S, as appropriate. All changes **not** on this form **must** be reported using HCFA Forms 855, 855R, or 855S.

This form is not to be used to report a change of ownership (CHOW) as defined in 42 CFR § 489.18. A change of ownership requires the new owner to submit a completed HCFA Form 855 (General Enrollment Application). However, the current owner should complete the Potential Termination of Current Ownership section of this form to report that a potential change of ownership may occur.

Check Type of Change Being Reported

Check all changes that apply.

1. Provider/Supplier Identification

Complete provider/supplier's full name, social security number and employer identification number as it is currently on file at the Medicare or other federal health care contractor. The current Medicare or other federal health care program identification number must be provided (e.g. UPIN, NSC, OSCAR, PIN, NPI).

For legal business name, supply the name that the individual or entity uses in reporting to the Internal Revenue Service (IRS), as well as the individual's or entity's employer identification number (EIN) as it is currently on file at the Medicare or other federal health care contractor. If the EIN has changed, a new enrollment application (HCFA Form 855 or 855S) must be completed.

2. Name Change Information

If the provider/supplier is reporting a name change, complete applicable changes to the individual, organization or group name, and/or the "doing business as" name in the appropriate section. If an organization or group is requesting a name
If the provider/supplier wishes to deactivate his/her Medicare or other federal health care program billing number, identify the type of Medicare or other federal health care program billing change, an IRS Form CP 575 or other official IRS correspondence must be submitted showing the new name and the tax identification number related to the new name.

3. Address/Telephone Number Change Information

Complete provider/supplier's new mailing address. This is where the provider/supplier receives notices from the Health Care Financing Administration or other federal health care programs.
Complete the "Pay To" address section if provider/supplier would like payments to go to an To" address currently on file. This address may be a Post Office box.
If the provider/supplier is reporting a billing agency or management service organization address change, complete identifying information for the current agency or organization and furnish the new address. If the provider/supplier is reporting a **NEW** billing agency or management service organization, do not use this form. Provider/supplier must complete the Provider/Supplier Identification and Billing Agency/Management Service Organization Address sections in the HCFA Form 855 (General Enrollment Application) and submit a copy of the new billing agreement or contract.

If provider/supplier is changing the location of the current practice, complete all information requested for the new location where provider/supplier will render services to Medicare or other federal health care program beneficiaries. If establishing a concurrent location (in addition to the current location), a new HCFA Form 855 (General Enrollment Application) must be completed for the **new** location. If deleting a current practice location, check the appropriate box.

A Post Office box or drop box is **not** acceptable as a practice location address. The phone number must be a number where patients and/or customers can reach the provider/supplier to ask questions or register complaints.

Indicate whether patient records are kept at the new practice location. If records are not kept at the new practice location, supply the physical address where the records are maintained. A Post Office or drop box address is **not** acceptable for records storage.

4. Provider/Supplier Specialty

Complete this section if provider/supplier's primary and/or secondary specialty is changing.

5. Medicare or Other Federal Health Care Program Billing Number Deactivation Information

number (e.g. UPIN, NSC, OSCAR, CHAMPUS) and provide the billing number, the effective date of deactivation for that billing number, and the reason for deactivation. Provider/suppliers

may deactivate any and all Medicare or other federal health care program billing numbers as necessary by listing all applicable numbers, their types, and effective dates of deactivation as outlined above. However, applicant must notify each individual federal agency regarding the deactivation of the number(s) under that agency's control.

6. Addition/Deletion of Authorized Representative

Complete this section if provider/supplier wishes to delete a currently listed authorized representative, or the provider/supplier would like to report a new authorized representative.

An Authorized Representative is the appointed official (e.g., officer, chief executive officer, general partner, etc.) who has the authority to enroll the entity in Medicare or other federal health care programs as well as to make changes and/or updates to the applicant's status, and to commit the corporation to Medicare or other federal health care program laws and regulations.

The original signature of the new authorized representative is required to add a new authorized representative.

7. Surety Bond Information

This section to be completed by all providers/suppliers for which a surety bond is required.

Annual renewals must be reported to the Medicare or other federal health care program contractor using this Change of Information form - HCFA Form 855C.

An original copy of the surety bond must be submitted with this form. Failure to submit an original copy of the surety bond will prevent the processing of this form. In addition, the surety bond company must submit a certified copy of the agent's Power of Attorney with this form, if the bond is issued by an agent.

Note: It is the responsibility of the provider/supplier to obtain and submit with this form a certified copy of the surety bond agent's Power of Attorney from the surety bond company, if the bond is issued by an agent.

8. Potential Termination of Current Ownership

When a business or organization is planning a change of ownership which is in accordance with the provisions for Change of Ownership (CHOW) as defined in 42 CFR § 489.18, the current owner must furnish the name of the potential new owner and the projected effective date of the potential change of ownership as soon as the possibility of such an action is known to the current owner.

Note: This section is not to be completed when the existing business/organization is adding or deleting a new owner. Changes of individual owners should be reported using the appropriate sections of HCFA Form 855 (General Enrollment Application).

9. Effective Date of Change(s)

Report the date all listed changes are effective.

10. Attestation Statement

Sign and date this form attesting to the accuracy of the requested changes. If changes are being reported on an individual provider/supplier, then that individual provider/supplier must sign this form. If the changes are being reported for an organization or group practice, an authorized representative of the organization or group practice must sign this form to confirm the requested change(s).

THIS FORM SHOULD BE RETURNED TO YOUR LOCAL MEDICARE OR OTHER FEDERAL HEALTH CARE PROGRAM CONTRACTOR. SEE THE RETURN ADDRESS AT THE BEGINNING OF THESE INSTRUCTIONS.

information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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MEDICARE/FEDERAL HEALTH CARE PROVIDER/SUPPLIER FORM
Change of Information Form

Type of Change (Check all that apply.)

- ☐ Name
- ☐ Practice Location Address
- ☐ Mailing Address
- ☐ Telephone Number(s)
- ☐ "Pay To" Address
- ☐ Billing Agency Address
- ☐ Specialty
- ☐ Fax Number(s)
- ☐ E-Mail Address
- ☐ Authorized Representative
- ☐ Deactivation of Medicare Billing Number(s)
- ☐ Potential Termination of Current Ownership
- ☐ Surety Bond Change or Renewal Information

1. Provider/Supplier Identification (Required)

Individual Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Other Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

OR

Business Name:

Social Security Number (if applicable)	Employer Identification Number (if applicable)	Medicare Identification Number(s) (if applicable)

2. Name Change Information

A. Individuals ONLY

Prior Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
New Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

Social Security Number (if applicable)	Employer Identification Number (if applicable)	Medicare Identification Number(s) (if applicable)

B. Organizations or Groups ONLY

New Legal Business Name	Employer Identification Number

C. "Doing Business As" Name

Under what new name do you conduct business?

_____

3. Address/Telephone Number Change Information

A. Mailing Address

New Mailing Address Line 1

New Mailing Address Line 2

New City	New State	New ZIP Code + 4

New Telephone Number	New Fax Number	New E-mail Address
( )	( )	

B. "Pay To" Address

New Mailing Address Line 1

New Mailing Address Line 2

New City	New State	New ZIP Code + 4	New Telephone Number
			( )

3. Address/Telephone Number Change Information (continued)

C. Billing Agency/Management Service Organization Address

Attach a copy of the most current signed contract with provider/supplier's billing agency or management service organization.

Name of Billing Agency/Management Service Organization				Employer Identification Number
Agency/Organization Contact Person Name: First	Middle	Last	Jr., Sr., etc.	Title
New Telephone Number ( )	New Fax Number ( )		New E-mail Address	
New Business Street Address Line 1				
New Business Street Address Line 2				
New City	New State		New ZIP Code + 4	

D. Practice Location(s) (For each additional location, copy and complete this section.)

Check whether adding or deleting the practice location identified below. ☐ Adding ☐ Deleting

New Street Address Line 1			
New Street Address Line 2			
New City	New County	New State	New ZIP Code + 4
New Telephone Number ( )	New Fax Number ( )	New E-mail Address	

Are all patient records stored at this new practice location? ☐ **Yes** ☐ **No** **IF NO, supply storage location below.**

Name of New Storage Facility/Location			
New Street Address Line 1			
New Street Address Line 2			
New City	New County	New State	New ZIP Code + 4
New Telephone Number ( )	New Fax Number ( )	New E-mail Address	

4. Provider/Supplier Specialty Change Information

New Primary Specialty	New Secondary Specialty

5. Medicare or Other Federal Health Care Program Billing Number Deactivation Information

Type (OSCAR, UPIN, PIN, etc.)	Medicare/Other Federal Health Care Program Number	Effective Date of Deactivation (MM/DD/YYYY)
Reason for deactivation request?		

6. Addition/Deletion of Authorized Representative

For each additional authorized representative, copy and complete this section.

☐ **Addition of Authorized Representative**
Effective date (MM/DD/YYYY) _____

☐ **Deletion of Authorized Representative**
Effective date (MM/DD/YYYY) _____

Authorized Representative Name: (printed) First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Title/Position	Social Security Number	Medicare Identification Number(s) (if applicable)		
Authorized Representative Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	

7. Surety Bond Change or Renewal Information

An original copy of the current surety bond must be submitted with this section.

A certified copy of the surety bond agent's Power of Attorney must be submitted with this section.

Name of Surety Bond Company	Telephone Number ( )	Fax Number ( )

Agent's Name: First	Middle	Last	Jr., Sr., etc.

Amount of Surety Bond $	Effective Date (MM/DD/YYYY)
Bond for Tax Year:	Annual Renewal Date (MM/DD/YYYY)

8. Potential Termination of Current Ownership

Furnish name of potential new owner and projected effective date of change of ownership.

Individual Name of Potential New Owner: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
OR				

Legal Business Name of Potential New Owner:

Projected Effective Date of Change of Ownership (MM/DD/YYYY)	Medicare Identification Number of Potential New Owner (if applicable)

9. Effective Date of Change(s)

This change/these changes are effective as of

_____ (MM/DD/YYYY)

10. Attestation Statement

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of material information may subject me to liability under civil and criminal laws.

Provider/Supplier Name: First (printed)	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

Provider/Supplier Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY)

or for groups and organizations:

Authorized Representative Name: First (printed)	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

Title/Position	Social Security Number	Medicare Identification Number (if applicable)

Authorized Representative Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	Date (MM/DD/YYYY)