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			***Individual***
__ New IRS Verification	__New CLIA	__New Medicare	__New Social Security Card
__ New Accreditation	__New JCAHO	__New HME	__ New Medical License
__New Facility 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:** _____