 **New Mexico Medicaid**

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| **How to use this form:*** Only one provider may be updated per form
* Please complete all applicable information, sign and date this form (page 3), and send to the address indicated to the right
* Please allow 10 calendar days from date of mailing to process your updates
 | **MAIL TO**:Conduent State Healthcare, LLCAttn: Provider EnrollmentP.O. Box 27460Albuquerque, NM 87125 |

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| Date\*: |   | New Mexico Medicaid Provider Number\*: |       |
| Provider Name\*: |  | Tax ID (EIN or SSN)\*: |  |
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| [ ]  **UPDATE** **PROVIDER NAME** – Provide documentation for name change. (Examples for individuals: marriage license/divorce decree and professional license reflecting the name change. Examples for organizations: Sales transaction document, W-9 and IRS letter.) |
| Provider Name: |  |
| Comment: |  |
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| [ ]  **UPDATE** **NATIONAL PROVIDER IDENTIFIER (NPI)** – Provide print out from NPPES with new NPI and explanation for NPI change. |
| Number: |  |  | Effective Date: |   |
| Comment: |  |
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| [ ]  **UPDATE** **TAX INFORMATION** – Provide documentation for any changes. Updates to tax ID and business type require W-9, IRS letter, and a signed letter explaining the change. Note: for change of ownership you must include sales transaction document. You will be notified if a new provider participation agreement (application) is required. |
| TAX ID (EIN or SSN): |   | Effective Date: |   |
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| [ ]  **BUSINESS TYPE** |
| [ ]  Corporation | [ ]  Limited Liability Company |
| [ ]  Individual/Sole Proprietor | [ ]  Non-corporate Business Entity |
| [ ]  Partnership/Professional Association | [ ]  Government Entity or Public School |
| [ ]  **UPDATE ADDRESS** – Update any or all of your addresses (Address boxes left blank will not be changed.) |
|  Billing – Used for payments |  Physical – (P.O. Box not acceptable) require  |  Mail-To – Used for correspondence |
| The billing address does not pertain to service only providers. | A change in the physical address for an organization requires a copy of your City Business License or a signed letter explaining why you are exempt from this requirement.  | Addresses must be verifiable with the United States Postal Service. |
| Street | Street | Street |
|       |       |       |
| City | City | City |
|       |       |       |
| State County Zip | State County Zip | State County Zip |
|       |       |       |       |       |       |
| Phone Number | Phone Number | Phone Number |
|       |       |       |
| Fax Number | Fax Number | Fax Number |
|       |       |       |
| E-mail | E-mail | E-mail |
|       |       |       |

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| [ ]  **UPDATE LICENSURE or CERTIFICATION** – Provide documentation for the item being updated. Submitted documentation must come from the issuing board. |
| Number: |       | Effective Date: |   | Exp Date: |   |
| Documentation: | [ ]  | Copy of Updated License | [ ]  | Copy of Updated Certification |  |
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| [ ]  **ADD AFFILIATION(S)** – Add affiliation(s) to your provider file (attach additional sheets if needed) Attach proof of liability insurance. Coverage dates must include requested effective date and be valid for at least 30 days after the submission date.  |
| Provider ID: |       | Name: |       | Eff. Date: |   |
| Provider ID: |       | Name: |       | Eff. Date: |   |
| Provider ID: |       | Name: |       | Eff. Date: |   |
| Provider ID: |       | Name: |       | Eff. Date: |   |
| Provider ID: |       | Name: |       | Eff. Date: |   |
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| [ ]  **END AFFILIATION(S)** – End affiliation(s) from your provider file (attach additional sheets if needed) |
| Provider ID: |       | Name: |       | End Date: |   |
| Provider ID: |       | Name: |       | End Date: |   |
| Provider ID: |       | Name: |       | End Date: |   |
| Provider ID: |       | Name: |       | End Date: |   |
| Provider ID: |       | Name: |       | End Date: |   |
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| [ ]  **BACKDATE ENROLLMENT** – Attach proof of liability insurance and professional or business license covering the requested backdate and explanation for backdate request. |
| Please backdate my enrollment effective date to: |   | (MM/DD/YYYY format) |
| Comment:  |

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| [ ]  **TERMINATE ENROLLMENT** – Indicate the reason(s) for termination and effective date |
| [ ]  Change of Ownership/Not re-enrolling  | [ ]  Voluntary Termination  |
|  | [ ]  Provider deceased |
| [ ]  Other Reason/Comment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Last day in business: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| [ ]  **OTHER UPDATE –** Briefly describe in the comment section below.Comment: |

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| **CERTIFICATION STATEMENT** – Please read the following, sign, and date |
| I certify by my signature below that I am fully authorized to sign and execute this Enrollment Update on behalf of the aforementionedProvider. I understand that any information requested and provided on this form does not change or alter the terms of my executed ProviderParticipation Agreement. I further understand that any false claims, statements, documents, or concealment of material fact may be grounds for termination as a New Mexico Medicaid Provider, and/or may be prosecuted under applicable federal and state laws. |
| Name\*: |       | Email\*: |       |
| Signature\*: |  | Date\*: |   |
| An authorized agent must sign for an organizational provider or the actual provider must sign if you are an individual provider. |
| *Unsigned forms will not be processed and will be returned.* |