**New Mexico Medicaid** 

**How/When to use the form:**

* Only one provider may be updated per form.
* For use when updating addresses, e-mail address, phone numbers, NPI, licenses and certifications, affiliations, and enrollment status.
* Complete the sections appropriate for your request and all required sections.
* Please allow 10 calendar days from date of mailing to process your update.

**How to complete the form:**

**Provider Information (Must be completed for every request)**

* Date: Enter the date you are making this request.
* New Mexico Medicaid Provider Number: Enter your 8 digit New Mexico Provider Identifier.
* Provider Name: Enter your legal name.
* Tax ID: Enter your EIN or SSN.

**Provider Name**

* Provider Name: Enter provider name
* Comment: Enter reason for change
* Please note: You must 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.

**National Provider Identifier (NPI)**

* Number: Enter the billing provider’s 10 digit National Provider Identifier.
* Effective Date: Enter the effective date of your NPI.
* Comment: Enter reason for change
* Please note: You must provide a print out from NPPES with new NPI and

**Tax Information and Business Type**

* Tax ID (EIN or SSN): Enter the billing provider’s 9 digit tax number
* Effective Date: Enter the effective date of the tax number.
* Business Type: Please select one business type from the available options
* Please note: You must 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.

**Address**

* Billing: Enter the street or P.O. Box, city, state, county, zip code, phone number, fax number and email address you wish to have on file for billing purposes.
* Physical: Enter the street, city, state, county, zip code, phone number, fax number and email address of your physical address. You may not enter a P.O. Box number. A change in the physical address may require a copy of your City Business License or a signed letter explaining why you are exempt from this requirement.
* Mail-To: Enter the street or P.O. Box, city, state, county, zip code, phone number, fax number and email address you wish to have on file for official correspondence.

**Licensure or Certification**

* Number: Enter the number as it appears on your license or certification.
* Effective Date: Enter the effective date that appears on your license or certification.
* Exp Date: Enter the expiration date that appears on your license or certification.
* Please note: You must attach a copy of the license or certification. Submitted documentation must come from the issuing board.

**Add Affiliations**

* Provider ID: Enter the 8 digit New Mexico Provider Identifier of the provider you wish to affiliate.
* Name: Enter the legal name of the provider you wish to affiliate.
* Eff Date: Enter the date you wish this affiliation to become effective.
* Complete more lines for each provider you would like to affiliate. Add additional sheets if necessary.
* Please note: You must attach proof of liability insurance to form for each provider you are affiliating. Coverage dates must include requested effective date and be valid for at least 30 days after the submission date.

**End Affiliations**

* Provider ID: Enter the 8 digit New Mexico Provider Identifier of the provider you wish to dis-affiliate.
* Name: Enter the legal name of the provider you wish to dis-affiliate.
* End Date: Enter the date you wish this dis-affiliation to become effective.
* Complete more lines for each provider you would like to affiliate. Add additional sheets if necessary.

**Backdate Enrollment**

* Date: Enter the date you wish to be backdated.
* Comment: Enter reason for back dated enrollment.
* Please Note: you must include proof of liability insurance and professional or business license covering the requested backdate and explanation for backdate request.

**Terminate Enrollment**

* Check boxes: Select the most appropriate reason for terminating your enrollment.
* Comments: Change of Ownership (CHOW) or if Voluntary Termination, please provide additional comments explaining your reason for termination.
* Contact Info: Please enter contact name and phone number in the event we need to ask for additional information regarding your request to terminate.
* Last day in business: Enter the date you wish to have your enrollment status terminated.

**Other Update**

* Comments: Please provide additional update comments
* Please remember to attach documentation for any item that requires additional verification

**Certification Statement (Must be completed for every request)**

* Please read certification statement.
* Name: Enter the name of the person submitting this request.
* Email: Enter the email address where we could contact you during normal business hours if we have questions regarding this request.
* Signature: Signature of individual authorizing us to process this request.
* Date: Enter the date the request is being made.