

## **INSTRUCTIONS FOR COMPLETING THE REQUEST TO UPDATE PROVIDER INFORMATION**

**WHO INITIATES THE FORM:** THE REQUESTING AGENCY

**DATE:** THE DATE FOR FORM WAS SUBMITTED

**TO:** THE NAME OF THE LEAD DISTRICT CHIEF (LDC)WHO HAS RESPONSIBILITY FOR THE AGENCY

**SERVICE AREA OR BUREAU** THE LDC'S SERVICE AREA OF RESPONSIBILITY, I.E.  
1 - 8

**FROM:** THE NAME OF THE PROVIDER DIRECTOR (NGA)OR  
THE PROGRAM HEAD (DMH) RESPONSIBLE FOR THE  
AGENCY

**TELEPHONE NUMBER:** THE TELEPHONE NUMBER WHERE DMH CAN  
CONTACT THE DIRECTOR OR THE PROGRAM HEAD

**PROVIDER NO:** THE FOUR DIGIT PROVIDER NUMBER

**PROVIDER NAME:** THE ENTIRE PROVIDER NAME (NOT INITIALS)

**PROVIDER TELEPHONE NO:** PROVIDE THE NEW TELEPHONE NUMBER IF NEW.  
OTHERWISE LEAVE BLANK.

**PROVIDER FAX NUMBER:** PROVIDE THE NEW FAX NUMBER IF NEW.  
OTHERWISE LEAVE BLANK.

**PROVIDER DIRECTOR NAME:** PROVIDE THE NEW DIRECTOR OR PROGRAM HEAD  
NAME IF NEW. OTHERWISE LEAVE BLANK.

**EMAIL ADDRESS:** PROVIDE THE NEW EMAIL ADDRESS IF NEW.  
OTHERWISE LEAVE BLANK.

**HEAD OF SERVICE NAME:** PROVIDE THE HEAD OF SERVICE NAME IF NEW.  
ATTACH A COPY OF THE HOS CLINICAL LICENSE.  
OTHERWISE LEAVE BLANK.

**EMAIL ADDRESS:** PROVIDE THE NEW EMAIL ADDRESS IF NEW.  
OTHERWISE LEAVE BLANK.

**OTHER PROVIDER CHANGES:** CONTACT YOUR LDC DIRECTLY TO REPORT OTHER  
PROVIDER CHANGES.

**SIGNATURE:** THE PROVIDER DIRECTOR OR THEIR DESIGNEE MUST  
SIGN THIS FORM

**APPROVAL SIGNATURE:** THE LDC MUST SIGN THE FORM ACKNOWLEDGING  
RECEIPT OF THE FORM AND THE COPY OF THE  
LICENSE IF APPLICABLE.

**DISTRIBUTION:** THE LCD IS RESPONSIBLE FOR SENDING A COPY TO  
CIOB TO UPDATE THE DMH DATA SYSTEM. THE  
LDC WILL ALSO SEND A COPY TO PROGRAM  
SUPPORT BUREAU/CERTIFICATION UNIT FOR ANY  
UPDATES TO THE HOS.