

NETWORK PROVIDER CHANGE REQUEST

Note: For NEW Providers, please fill out the Agency Information Form (located at www.mycare.com/contracting)

1. Agency Type (Please Select All Applicable): Home Health Agency Durable/Home Medical Equipment

2. Legal Agency Name: _____ **DBA Name:** _____

3. Address _____ **City** _____ **State** _____ **Zip Code** _____

4. National Provider Identifier #: _____ **Federal Tax I.D. #:** _____

5. Name and Title of Person Completing This Form:

Name _____ **Title** _____

Email _____ **Phone** _____

6. Reason for Request (Please Select All Applicable):

<input type="checkbox"/> Location Addition- Please complete the Agency Information Form located here: https://www.mynexuscare.com/contracting/	<input type="checkbox"/> Service Area Change- Please complete the Service Area Form located here: https://www.mynexuscare.com/contracting/	<input type="checkbox"/> Scope of Service Change- Please complete the Scope of Services form located here: https://www.mynexuscare.com/contracting/
<input type="checkbox"/> Rate Change	<input type="checkbox"/> Language Change <input type="checkbox"/> Spanish <input type="checkbox"/> Sign Language Other: _____	<input type="checkbox"/> Agency Name Change Old: _____ New: _____
<input type="checkbox"/> Change in Ownership (see #8 below)	<input type="checkbox"/> Contract Term Term Effective Date: _____	<input type="checkbox"/> Phone Change Old: _____ New: _____
<input type="checkbox"/> Fax Change Old: _____ New: _____	<input type="checkbox"/> NPI Change Old: _____ New: _____	<input type="checkbox"/> Tax ID Change Old: _____ New: _____
<input type="checkbox"/> Other: _____ _____		

7. Effective Date of Change: _____

8. If you have an ownership change to report, did this result in a change to the following?

Federal Tax id #	Yes	No	Medicare #	Yes	No	NPI	Yes	No
Address	Yes	No	Agency Name	Yes	No			

Important Note:
 All requests will be evaluated pursuant to the terms and conditions of your current Provider Participation Agreement. Someone will contact you shortly to go over these changes.

FOR QUESTIONS OR TO SUBMIT FORM, PLEASE RETURN

➤ **VIA FAX AT 615-988-9947** **OR** ➤ **VIA EMAIL AT provider_network@mynexuscare.com**

I understand that **checking this box** confirms that I acknowledge and **agree** to the above changes.

Signature: _____ Date: _____