myNEXUS™
Intelligent care. Connected.

Home Based Health Care Provider

CURRENT NETWORK PROVIDER CONTRACTING CHANGE REQUEST

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

1. Agency Type (Please Select All Applicable):

☐ Home Health Agency ☐ Durable/Home Medical Equipment ☐ Specialty Pharmacy for Infusion Therapy ☐ Other

2. Legal Agency Name:

3. Doing Business As (DBA) Name:

4. Agency Contact Information:

Phone Number: **Fax Number:**

Toll-Free Phone Number: **Toll-Free Fax Number:**

5. Primary Contact Name and Title:

Email Address: **Phone Number:**

6. National Provider Identifier #:

Federal Tax I.D. #:

CMS Certification Number:

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

☐ Location/Branch Addition ☐ Service Area Change ☐ Scope of Service Change ☐ Contract Termination

☐ Rate Change ☐ Language Change ☐ Other: ____

***Important Notes:**

- For New Providers, including Location Additions, please fill out the Agency Information Form located at www.mynexuscare.com/contracting.
- All requests will be evaluated pursuant to the terms and conditions of your current Provider Participation Agreement.

8. Effective Date of Change:

9. Description of Change:

FOR QUESTIONS OR TO SUBMIT FORM, PLEASE RETURN TO ATTN: PROVIDER NETWORK:

- **VIA FAX AT 615-988-9947** **OR**
- **VIA EMAIL AT** CONTRACTING@MYNEXUSCARE.COM

For Internal Use Only:

Department:			
Sign-Off (Initials) / Date:			