NETWORK PROVIDER 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

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):**

☐ Location Addition- Please complete the Agency Information Form located here: https://www.mynexuscare.com/contracting/	☐ Service Area Change- Please complete the Service Area Form located here: https://www.mynexuscare.com/contracting/	☐ Scope of Service Change- Please complete the Scope of Services form located here: https://www.mynexuscare.com/contracting/
☐ Rate Change	☐ Language Change ☐ Spanish ☐ Sign Language Other: _____	☐ Agency Name Change Old: _____ New: _____
☐ Change in Ownership (see #8 below)	☐ Contract Term Term Effective Date: _____	☐ Phone Change Old: _____ New: _____
☐ Fax Change Old: _____ New: _____	☐ NPI Change Old: _____ New: _____	☐ Tax ID Change Old: _____ New: _____
☐ 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 629-204-3053** **OR** - **VIA EMAIL AT** ProviderDataManagement@myNEXUScare.com

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

Signature: _____ Date: _____