DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

(Only to be completed by approved DBHDD providers requesting a Change of Information.
Must submitted along with the Department of Community Health (DCH) Change of Information Form)

This form is used to make modifications to provider information maintained in the Department of Behavioral Health and Developmental Disabilities provider system. To be completed by approved providers requesting a Change of Information. This form must be submitted along with the Department of Community Health (DCH) Change of Information Form for approved Medicaid services.

The Department of Community Health (DCH) Change of Information Form can be found at the following link: DCH Change of Information form

Only one provider number may be modified per form. Please complete the section pertaining to your request. This form **CANNOT** be used for a Change of Ownership. **A Change of Ownership requires that a new application for enrollment be submitted.**

Instructions:

Check the type of change being reported.

Enter the Georgia Medicaid/ Peachcare for Kids Provider Number for which changes are being made.

1. Current Provider Identification (Required)
Complete provider's full name or business name as it is currently on file with DBHDD. Enter the current address that is currently on file with DBHDD. Enter the Tax Identification number as applicable.

2. New Agency Name / Location/Name Information
If the provider is reporting a name change, complete applicable changes to the Agency name or Location name in the appropriate section. For any name change the provider must submit a certified copy of the legal document(s) showing the old and new names.

3. New Address/Telephone Number Information

Check "Mailing Address" if the provider would like correspondence to go to an address other than the mailing address that is currently on file. A Post Office Box **is** acceptable as the mailing address.

Check "Location Address" if the provider is making a change in the physical address of the service site. A Post Office Box **is not** acceptable as the physical location address. A change in physical address must be communicated to the regional office and a site visit performed for some services.

4. Effective Date of Change(s) (Required)
Report the date on which all listed changes are effective.

5. Attestation Statement (Required)
Sign and date this form attesting to the accuracy of the requested changes. An authorized representative of the agency must sign this form to confirm the requested change(s).

Return this form with any necessary attachments to:

Provider Enrollment Unit
Office of Provider Network Management
Department of Behavioral Health and Developmental Disabilities
2 Peachtree Street, 23rd Floor
Atlanta, Georgia 30303

Fax: 404-463-6678
Email: mhddad-serviceapps@dhr.state.ga.us

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

DBHDD CHANGE OF INFORMATION FORM

Only to be completed by approved DBHDD providers requesting a Change of Information.
Must be submitted along with the Department of Community Health (DCH) Change of Information Form, for approved Medicaid services

Type of Change (Check all that Apply)	**❒ Legal Name** **❒Address Information (Include updated HFR licenses, if required.)**	**❒ Taxpayer I.D.** **❒ Telephone / Fax Number** **❒ Deactivation of Participation**

Medicaid Provider Number, if applicable (ONE PROVIDER NUMBER PER FORM): _____

1. Current Provider Information (Required)			
Agency Name:		**Taxpayer ID#:**	
Currently Approved Address:			
For Residential Services Only, license is: **❒CLA** **❒ PCH** **❒ Host Home*** ***If Host Home indicate Host Home Provider's Name:**			
2. New Agency Name / Location / Tax ID Information			
New Legal Agency Name:			
DBA Name, if applicable:			
New Location Name:			
Taxpayer I.D. # (Attach W9)			
3. New Address / Telephone /Fax Number Information (Check the one that applies)			
❒ Mailing Address **❒ Location Address**			
New Address Line 1:			
New Address Line 2:			
New City:	**New State:**	**New Zip Code:**	**New County:**
New Telephone #:	**New Fax:**	**New Email Address:**	
4. Requested Effective Date of Change (s) (Required)			
This change / these changes are effective as of (MM/DD/YY):			
5. Attestation Statement (Required)			
I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of material information may subject me to liability under civil and criminal law.			
Authorized Representative's Name (print):	**Title:**		
Authorized Representative's Signature:	**Date:**		