Vermont Medicaid Update Address Request Form

Please fax completed form to 802 878-3440 Attn: Provider Enrollment

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Provider Number: __________________ Provider Name: ___________________________________

Contact number of individual completing form: __________________________

I wish to change the address to which my Correspondence & Recertification Notifications are sent:

Mail to Address

Address change effective date: ______________ *(mm/dd/yyyy)* Address: _________________________________

Address: _________________________________ City: _____________________________________

State: _______________________Zip:______________

Telephone Number: ______________________________

Please send my Medicaid Checks and/or my Remittance Advice to the address below (Pay to Address)

Address: _____________________________ Address: _____________________________

City: _____________________________ State: ______________ Zip: ___________

Each address where Medicaid patients are seen must be listed in your provider Medicaid record, on file in our office. If no service address changes are necessary leave this section blank. Please list the address or addresses you wish to update and circle the address action taking place below (ADD, CHANGE OR REMOVE). **Note: A service address must be a street address and not a PO Box Service.**

(*Photocopies of this page may be used when reporting more than one service address addition or change)*

Address: **ADD** **CHANGE** **REMOVE**

Address: ______________________________ Address: ______________________________

City: __________________________________ State: ________________Zip:__________ Telephone: ___________________

Handicap Accessible? Yes ___ No ___ Partial____

Languages Accommodated in office: ______________________________

Patient Age Limits: All Ages ______Newborn______ Age Range *(to)* ______ *(from)* _____

Established Patients Only? ___________

Billing Service Address

Address: ___________________________________

Address: ___________________________________

City: ______________________________________

State: ____________________Zip:______________

Provider Signature or Signature of Authorized Party: _____________________________ **Date Signed:** _____________

Title of Authorized Party: ______________________________ **Contact Number:** _________________________