# Facility Change of Address Form

Please list **ALL New/Current addresses** in addition to any addresses we should delete from our files. Provider #: _____

| Facility Name: | State: |
|---|---|
| E-Mail Address: | Primary Contact: |

**1** *All addresses listed below must correspond to the Tax Identification Number (TIN) listed. **If you have more than one TIN, please complete a separate address change form for each TIN currently in use.**

*The TIN indicated below is a ☐ TIN currently in use ☐ New TIN (Please complete a W-9 form)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

TIN Owner Name (Must match W-9): _____

**Please complete separate forms for multiple Service Addresses.** ***NEW Service Locations require a Service Location Addendum.***

**2 DELETE** this Service Address: Effective Date (Required) / /
(Referrals)

Street Address/Suite

City State Zip

Phone ( ) Fax ( )

**3 ADD/KEEP** this Service Address: Effective Date (Required) / /
(Referrals)

Street Address/Suite (No PO Box)

City State Zip

Phone ( ) Fax ( )

Handicapped accessible ☐Y / N☐ Public Transportation accessible ☐Y/ N☐

**4 DELETE** this Service Address: Effective Date (Required) / /
(Referrals)

Street Address/Suite

City State Zip

Phone ( ) Fax ( )

**5 ADD/KEEP** this Service Address: Effective Date (Required) / /
(Referrals)

Street Address/Suite (No PO Box)

City State Zip

Phone ( ) Fax ( )

Handicapped accessible ☐Y / N☐ Public Transportation accessible ☐Y/ N☐

**6 DELETE** this Mailing Address: Effective Date (Required) / /
(Certification Letters)

Street Address/Suite

City State Zip

Phone ( ) Fax ( )

E-Mail Address: _____

**7 ADD/KEEP** this Mailing Address: Effective Date (Required) / /
(Certification Letters)

Street Address/Suite

City State Zip

Phone ( ) Fax ( )

E-Mail Address: _____

**8 DELETE** this PayTo Address: Effective Date (Required) / /
(Payment)

Street Address/Suite

City State Zip

Phone ( ) Fax ( )

**9 ADD/KEEP** this PayTo Address: Effective Date (Required) / /
(Payment)

Street Address/Suite (No PO Box)

City State Zip

Phone ( ) Fax ( )

**10** Provider Signature (Required): _____ Date: _____

Fax completed form to: (866) 497-9265 or mail to Carelon Behavioral Health PO Box 989 Latham, NY 12110. For questions please call (800)-397-1630.

**Address updates can be completed online via ProviderConnect.**