

Notification of Change Form

[Health Home Name and Address]

Date: [Date]

NPI#: [NPI]

Provider MMIS#: [MMIS#]

This Notification of Change Form is used to inform the NYS Department of Health of any changes made to your Health Home from your originally approved Health Home application and designation letter. Please check all that apply:

Changing Designated Corporate Name:

- Our current Health Home name as listed on our application is: _____
- The new name is: _____

We are not changing our NPI number, but changing our name by doing business as (DBA):

- The new name is: _____.

Applying for a new NPI number: (<https://nppes.cms.hhs.gov/NPPES/Welcome.do>)

- Our current NPI# is: _____. The new NPI# is: _____. (NPI# is pending ____)

Additional Requirements: A *Certificate of Assumed Name* may be required by your Health Home organization. Further instructions on required documents can be found on the Department of State's website at:

<http://www.dos.ny.gov/index.html>. Lead Health Homes that hold certifications as clinics or hospital-based providers under Article(s) 28, 31 and/or 32 that change their name and/or apply for new NPI#s after receipt of their NYS Approved Health Home Letter, are requested to contact respective agency staff for any additional guidance. Contact information regarding Article(s) 28, 31 and 32 is located on the Health Home website at:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/medicaid_enroll_provided_hh_rev.htm

Change in Health Home Corporate Structure: Merger ____ Separate ____ Other _____

- Attach a detailed description of the changes and indicate how they will impact your Health Home service model

Change in Care Management Tool:

Billing Agent: We will remain the lead Health Home, but will be using a new billing agent whose name is _____, NPI# _____.

Partner Network: Our Health Home partner network is changing as follows: _____

- Attach a detailed description of the changes and indicate how they will impact your Health Home service model.
- Change in Designated Service Counties:** Expansion ____ Withdrawal ____
 - Attach a detailed description of the changes and indicate how they will impact your Health Home service model.
- For changes in Health Home name, corporate structure, or network partners, we have contacted, or will contact, the DOH privacy officer regarding completing any amendments to our Data Exchange Application Agreements (DEAAs).
- For changes in Health Home name or network partners, we acknowledge our Consent Form (5055) must be updated by (6 months) to reflect our new Health Home name and any changes in our network partners.

If you have any questions regarding this letter please contact _____ at telephone # _____.

Sincerely,

Signature of CEO/Executive Director Date Telephone #

Please return the completed and signed Notification of Change Form to:

Health Home Program
New York State Department of Health
Office of Health Insurance Programs
Division of Program Development and Management
Corning Tower, OCP-720
Albany, New York, 12237