

Notification of Change Form

This Notification of Change Form (NOC) is for the Lead Health Home (HH) to inform the NYSDOH of any changes. Please follow the "Instructions for Using the Notification of Change Form" document to complete this NOC form.

NOTE: changes in sections 2, 4, 8.b., and 9 require a detailed explanation to be submitted along with this form.

Health Home Name:

Address:

Date:

NPI#:

Provider MMIS#:

Health Homes Changes (Lead Health Home use only):

1. **Program Name Change (select one)**
 - a. **Changing Designated Corporate Name**

Our current Health Home name as listed on our application is:
The new name is: Effective Date:
 - b. **We are not changing our NPI number, but changing our name by doing business as (DBA)**

The new name is: Certificate of Assumed Name attached
 - c. **We are changing our NPI number, and changing our name by doing business as (DBA)**

The new name is: Certificate of Assumed Name attached
2. **Corporate Structure Change (DOH approval required prior to change):**
3. **New/Change to Health Home or Care Management Agency MMIS/NPI:**
 - a. **Health Home** b. **CMA**
Current MMIS/NPI#: New MMIS/NPI#:
4. **Designated Service Counties Change (DOH approval required prior to change):**

Requested County(ies):
5. **Billing Vendor Change:**

New Vendor Name: NPI#:
6. **RHIO Connectivity Change:**

Type of Change: **Connecting to RHIO** Terminating RHIO
RHIO Name: Effective Date:
7. **Care Management Platform/Electronic Health Record (EHR) Change:**

New EHR Name: Effective Date:
8. **CMA Relationship Change:** a. **HH adding CMA** b. **HH removing CMA (DOH approval required prior to change)**

CMA Name: CMA Email Contact:
MMIS #: Effective Date:
9. **Partner/Network Provider Change:** Add Provider or Remove Provider

Provider Name: Provider Type:
MMIS/NPI# (if applicable): Effective Date:

Executive Director Attestation

For changes in Health Home name, corporate structure, or network partners, we have contacted, or will contact, the NYSDOH Security and Privacy Bureau regarding completing any amendments to our Data Use Agreements (DUA). We acknowledge that all applicable health home consents (adults/children) will be updated according to procedures and time frames identified in the **Requirements and Instructions for Using the Notification of Change Form**.

Exec Dir Name:

HCS ID:

Date:

Phone:

Submit completed form to "Organizational Changes" drop down box on the Health Home website:

https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action