New York State Department of Health
Office of Health Insurance Programs
Division of Program Development and Management
Health Home Management Unit
Medicaid Policy and Care Delivery Group, OCP-720
Empire State Plaza, Corning Tower
Albany, New York, 12237

[Provider Name]
[Inside Address]

Date: [Date]
NPI: [NPI]
Provider MMIS#: [MMIS#]

Dear NYS Department of Health,

We are advising you in writing of our intent to make changes to our corporate name, NPI#, billing agent/or partner network, from our originally approved Health Home application and designation letter. Our changes reflect the following.

- ☐ Applying for a new NPI#.
  Our current NPI is: _____. The new NPI# is: _____. (Please check if NPI# is pending ___ (√).
  Our current Health Home name as listed on our application is: _____
  The new name is: _____.
- ☐ We are not changing our NPI#, but changing our name by doing business as (DBA).
  The new name is _____.
- ☐ We will remain the lead Health Home, but will be using a different agency as our billing agent whose name is_____, NPI# _____.
- ☐ We have contacted, or will contact, the privacy officer regarding completing an application to amend our DEAA.
- ☐ Our Health Home provider network is changing as follows:_____
  _____
- ☐ This change will have the following impact on our ability to deliver Health Home services:
  _____
  _____
- ☐ We have or will update our Consent Form to reflect 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 #