Change of Address Form Instructions

Signature

- The individual provider's signature is required for all changes requested for an individual provider number.
- Signature of the authorized representative for the group/facility is required for changes to group/facility provider numbers.

General

- Incomplete forms will be returned to the provider.
- If you have any questions, please contact Conduent Provider Enrollment at (800) 884-3222.

CHANGE OF ADDRESS FORM

Mail the completed form to: **Mississippi Medicaid Provider Enrollment**
P.O. Box 23078
Jackson, Mississippi 39225
or Fax to: 888-495-8169

Provider Information

Provider Name:

National Provider Identifier (NPI):

MS Medicaid Provider Number:

Contact Information

Contact Name: Phone Number:

Email Address:

Change of Address Information

Please check the appropriate boxes below for the address type(s) you wish to change.

☐ Servicing Address	Street Address (Must be a physical address)			
	City	County	State	Zip Code
	Phone Number		Fax Number	
☐ Billing Address	Street/P.O. Box Address			
	City	County	State	Zip Code
☐ Mail Other Address	Street/P.O. Box Address			
	City	County	State	Zip Code
☐ Remittance Advice Address	Street/P.O. Box Address			
	City	County	State	Zip Code
☐ 1099 Mailing Address	Street/P.O. Box Address			
	City	County	State	Zip Code
☐ **All Addresses**	Street/P.O. Box Address			
	City	County	State	Zip Code

Authorization for Change

I declare under penalty of perjury under the laws of the State of Mississippi that the information in this document and any attachments are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the aforesaid Provider. I understand that Mississippi Medicaid Provider Enrollment will use the information in this document and its attachments to change my provider file.

Provider/ Authorized Representative (Please Print Name)

Signature	**Date**

Revised 02/21/2017