State of Delaware

Office of Health Facilities Licensing and Certification

Complete form for any Name, Address and Phone Number Changes

Provider Type **(Check only one)**	ADC	ESRD	Hospice	Office-Based Surgery	PPECC
	ASC	FSEC	Hospital	OPT	PXR
	Birthing	HHA	IRF	PASA	

Current Information

State ID | Medicare Number (CCN) 08-

Provider Name

DBA

Provider Address

City | State | Zip Code

Phone | Fax

New Information

Provider Name

DBA

Provider Address

City | State | Zip Code

Phone | Fax

Administration Change/ Submit Resume

Title | Name

Phone Number | Fax Number

E-mail Address

Signature of Director/Administrator | Date

Effective Date of Change

Form must be printed, signed and sent to:

Email: DHSS_DHCQ_OHFLCFAX@DELAWARE.GOV

State of Delaware

Office of Health Facilities Licensing and Certification

261 Chapman Road, Suite 200

Newark, DE 19702

****If you are a Medicare certified provider, you must also submit a CMS-855 to your Medicare Administrative Contractor.**

For Office Use Only:

Application Reviewed & Approved By:_______________________________________ **Date:** ____________________