

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)

<input type="checkbox"/> ADC	<input type="checkbox"/> ESRD	<input type="checkbox"/> Hospice	<input type="checkbox"/> Office-Based Surgery	<input type="checkbox"/> PPECC
<input type="checkbox"/> ASC	<input type="checkbox"/> FSEC	<input type="checkbox"/> Hospital	<input type="checkbox"/> OPT	<input type="checkbox"/> PXR
<input type="checkbox"/> Birthing	<input type="checkbox"/> HHA	<input type="checkbox"/> IRF	<input type="checkbox"/> PASA	

Current Information

Provider Number _____ Medicare Number (CCN) 08- _____
Provider Name _____
Provider Address _____
City _____, DE Zip Code _____ County _____

New Information

Provider Name _____
Provider Address _____
City _____, DE Zip Code _____ County _____
Mailing Address (If different) _____
City _____ State _____ County _____

Miscellaneous Information

Phone Number _____ Fax Number _____
E-mail Address _____
Effective Date of Change _____
Name of Administrator _____
Signature of Administrator _____ Date _____

Form must be printed, signed and sent either by e-mail, fax or mail to:

E-mail: Amy-Joy.Andrews@Delaware.gov

Fax Number: (302) 292-3931

Mailing Address:
261 Chapman Road, Suite 200
Stockton Building
Newark, DE 19702
(302) 292-3930

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