State of Delaware
Office of Health Facilities Licensing and Certification
Change of Information Form

Please type this 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 License ID#　　　　Medicare Number (CCN) 08-

Provider Legal Name

Doing Business As (DBA)

Provider Address

City　　　　State DE　　　　Zip Code

Phone　　　　Fax

New Information

Provider Legal Name

Doing Business As (DBA)

Provider Address

City　　　　State DE　　　　Zip Code

Phone　　　　Fax

Administration Change/ Submit Resume

Job title　　　　Name

Phone Number　　　　Fax Number

E-mail Address

Signature of Director/Administrator　　　　Date

Effective Date of Change

Form must be typed, signed, and sent to:

Email: DHSS_DHCQ_OHFLCFAX@DELAWARE.GOV

****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:**