# Signature

Change of Address Form Instructions

* The individual provider’s signature is required for all changes requested for an individual provider number.
* Signature of the authorized representative is required for the group/facility/other provider types.

# General

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

|  |
| --- |
| **CHANGE OF ADDRESS FORM** |
| DOM Email Logo Mail the completed form to: **Mississippi Medicaid Provider Enrollment** P.O. Box 23078 Jackson, MS 39225 or Fax to: 866-644-6148 |
| **Provider Information** |
| Provider Name: |
| National Provider Identifier (NPI): |
| MS Medicaid Provider Number: |
| **Contact Information** |
| Contact Name: | Phone Number: |  |
| Email Address: |
| Fax Number:  |
| **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 +4 |
| Phone Number: |  | Fax Number:  |  |  |
| [ ] Pay To Address | Street/P.O. Box Address |
| City |  County | State |  | Zip Code +4 |
| [ ] Mail To Address | Street/P.O. Box Address |
| City | County | State |  | Zip Code +4 |
| [ ] Corporate Office Address  | Street/P.O. Box Address |
| City | County | State |  | Zip Code +4 |
| **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 10/10/2022