



Provider Change of Address Form

Please Note: Before completing this form, refer to the [Change of Address-Provider Requirements](#) for detailed instructions on filling out this form.

You can update your information with MassHealth via the Provider Online Service Center, using the “Manage Provider Information” feature. Alternatively, use this form to notify MassHealth of any updates to your information. This form is available at www.mass.gov/masshealth as an online fillable form. As stated in 130 CMR 450.223(B), providers must notify MassHealth within 14 days of any change. To view our regulations, please go to www.mass.gov/masshealth.

For any change in your legal entity, address, or check mailing address, you must submit an updated Request for Taxpayer Identification Number and Certification (Massachusetts Substitute W-9 form) with an original signature. You can download this form from our Web site at www.mass.gov/masshealth.

Providers are reminded that provider numbers are not transferable. For certain providers, approval of the new site or a new application may be required when there is a change to the “doing business as” address.

Please note that MassHealth cannot process changes to legal entity addresses or check mailing addresses that are not accompanied by a corresponding Massachusetts Substitute W-9 form with an original signature.

Fill in the following details. If any of the addresses below are left blank, the address will default to the one currently on file.

MassHealth provider ID/service location: _____ NPI no.: _____

(A) Legal Entity Address (P.O. boxes are NOT acceptable.)

Must include a Massachusetts Substitute W-9 form. Cannot fax or e-mail.

Address: _____

City: _____ State: _____ Zip code: _____ Effective date: _____

Telephone no.: _____ Fax no.: _____

TTY number (for people with partial or total hearing loss): _____

Contact name: _____ E-mail address: _____

(B) “Doing Business As” Address (P.O. boxes are NOT acceptable.)

Please refer to Change of Address—Provider Requirements for detailed instructions.

Address same as in section A C D E

Address: _____

City: _____ State: _____ Zip code: _____ Effective date: _____

Telephone no.: _____ Fax no.: _____

TTY number (for people with partial or total hearing loss): _____

Contact name: _____ E-mail address: _____

(C) Billing Address

Address same as in section A B D E

Address: _____

City: _____ State: _____ Zip code: _____ Effective date: _____

Telephone no.: _____ Fax no.: _____

TTY number (for people with partial or total hearing loss): _____

Contact name: _____ E-mail address: _____

(D) Check Mailing Address (same as remittance address on W-9)

Must include a Massachusetts Substitute W-9 form. Cannot fax or e-mail.

Address same as in section A B C E

Address: _____

City: _____ State: _____ Zip code: _____ Effective date: _____

Telephone no.: _____ Fax no.: _____

TTY number (for people with partial or total hearing loss): _____

Contact name: _____ E-mail address: _____

(E) Information Mailing Address (for bulletins and transmittal letters)

Address same as in section A B C D

Address: _____

City: _____ State: _____ Zip code: _____ Effective date: _____

Telephone no.: _____ Fax no.: _____

TTY number (for people with partial or total hearing loss): _____

Contact name: _____ E-mail address: _____

How do you want to receive bulletins and transmittal letters? Please check one:

Postcard (up to 10 days later than e-mail) E-mail (fastest) E-mail address: _____

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also certify that I am the provider or, in the case of a legal entity, duly authorized to act on behalf of the provider. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Provider's signature: _____

(Signature and date stamps, or the signature of anyone other than the provider or a person legally authorized to sign on behalf of a legal entity, are not acceptable.)

Printed legal name of provider: _____

Printed legal name of individual signing: _____

(if the provider is a legal entity)

Date: _____ **Contact tel. no.:** _____

Please return the completed form to the following address or fax number.

MassHealth Customer Service
ATTN: Provider Enrollment
P.O. Box 9162
Canton, MA 02021
Fax: 617-988-8974

Note: Changes to the legal entity address or check mailing address are not acceptable by fax or e-mail because they must include a Massachusetts Substitute W-9 form with an original signature.

If you have any questions, please call MassHealth Customer Service at 1-800-841-2900 or contact them by e-mail at providersupport@mahealth.net.