Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

EXISTING PROVIDER MODIFICATION DATA COLLECTION FORM

This form can be used only by existing MassHealth providers to modify the primary user information for an existing Provider and Service Location (PID/ SL). If you are submitting a provider enrollment application and want to initially establish a primary user for a new service location, please use the "Provider Enrollment Data Collection Form and Registration Instructions" at www.mass.gov/RegisterMassHealthProvider.

All sections marked with an asterisk (*) are required fields that must be completed by the submitter. Incomplete or handwritten forms will be rejected. Only one PID/SL per Data Collection (DC) form will be accepted. No more than five separate DC forms per request will be accepted.

*Provider name:	
*PID/SL(Provider ID/Service Location e.g. 110000123A)	

*Request type (Check one box):

☐	Replace the current primary user with a new primary user
☐	Establish a primary user (An active primary user does not currently exist in the organization)
☐	Unlink a primary user (Unlink the primary user from the PID/SL)

Existing primary user information (Required to replace, update, or unlink the primary user) Role will be removed.

First name	
Last name	
VG user ID	

New primary user information (Required to replace or establish a primary user)

Last name:	First name:	Middle initial:
VG user ID (* or check below to request ID):	Phone number:	

Check each box that applies

☐ Hearing aid search is required
☐ PACE/SCO/One Care is required
☐ Homeless medical respite (PT88 Only)
☐ Billing agency
☐ New primary user does not currently have a VG User ID [JG1.1](section below must then be completed)

Month and date of birth (MM/DD):	User-defined four digit PIN:
Email address:	

I certify that the information on this form and any attached statement that I have provided have been reviewed and signed by me and are true, accurate, and complete, to the best of my knowledge. 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.

I further acknowledge that I will review and adhere to the Commonwealth's standards for user access to its systems, including upon initial sign-in, and that my organization will comply with all the Commonwealth's standards for user access to its systems.

....
Provider's primary user signature | Date | Provider's signature | Date

(Only Adobe, Adobe Sign, and DocuSign are acceptable forms of electronic signature. Typed text of a signature is NOT acceptable. Provider's signatory must be an authorized agent.)

Please submit the completed Modification form to MassHealth at EOHHS-IT-CustomerService.Hancock@mass.gov.
It cannot be mailed or faxed. MassHealth will process your request within seven business days. Do NOT encrypt.