Commonwealth of Massachusetts

Executive Office of Health and Human Services [www.mass.gov/masshealth](http://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 PID/ SL (Provider and Service Location). If you are submitting a provider enrollment application and want to initially establish a Primary User for a brand-new service location, please use the “Provider Enrollment Data Collection Form and Registration Instructions” at [www.mass.gov/RegisterMassHealthProvider](http://www.mass.gov/RegisterMassHealthProvider).

Please note: All sections marked with an asterisk (\*) are required fields that must be completed by the submitter. Incomplete and handwritten forms will be rejected. Only one PID/SL per 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)

|  |  |
| --- | --- |
| 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: | |

D Check Here if Hearing Aid Search is also required

D Check here if New Primary User does not currently have a VG User ID (section below must then be completed)

|  |  |
| --- | --- |
| Month & 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.

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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.](mailto:EOHHS-IT-CustomerService.Hancock@mass.gov) It cannot be mailed or faxed. MassHealth will process your request within seven business days.