PROVIDER CHANGE OF ADDRESS FORM

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

Please Note: Before completing this form, refer to the Change of Address-Provider Requirements page on mass.gov for detailed instructions.

You can update certain information with MassHealth via the Provider Online Service Center (POSC), 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. Each MassHealth provider must notify the MassHealth agency prior to or no later than the date of the change. Failure to do so constitutes a breach of the provider contract which may be subject to fines or termination.

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) if you receive payments at this PIDSL. You can download this form from our website 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" (DBA) address.

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

MassHealth provider ID/service location (PID/SL)	NPI

(A) LEGAL ENTITY ADDRESS (PO BOXES ARE NOT ACCEPTABLE.)

Must include a Massachusetts Substitute W-9 form if you receive payments at this PIDSL.
Individual providers must list their home address in this section. For entities, you must list the address registered with the IRS for this FEIN.

MassHealth provider legal name			
Address: Number/Street			Building or Suite
City	State	Zip	Effective date
Telephone	Fax	Email	

(B) "DOING BUSINESS AS" ADDRESS (PO BOXES ARE NOT ACCEPTABLE.)

Please refer to Change of Address—Provider Requirements page on mass.gov for detailed instructions.
Address same as in section ☐ A

MassHealth provider DBA name			
Address: Number/Street			Building or Suite
City	State	Zip	Effective date
Telephone	Fax	TTY (for people with partial or total hearing loss)	
Contact name		Email	

(C) BILLING ADDRESS

Address same as in section (Billing address must match DBA address if the NPI is linked to more than one PID/SL) ☐ A ☐ B

MassHealth provider name

Address: Number/Street			Building or Suite
City	State	Zip	Effective date
Telephone	Fax	TTY (for people with partial or total hearing loss)	
Contact name		Email	

(D) CHECK MAILING ADDRESS (SAME AS REMITTANCE ADDRESS ON W-9). (THIS SECTION IS FOR BILLING PROVIDERS ONLY.)

Must include a Massachusetts Substitute W-9 form.

Note: MassHealth requires all providers to receive payment via EFT and the check mailing address would only be used if required while the EFT is being established and for notification by MassHealth Accounting.

Address same as in section ☐ A ☐ B ☐ C

Address: Number/Street			Building or Suite
City	State	Zip	Effective date
Telephone	Fax	TTY (for people with partial or total hearing loss)	
Contact name		Email	

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.

Printed name of provider _____ Signature _____

Printed legal name of individual signing (if the provider is a legal entity) _____

Date _____ Contact Email _____ Contact tel. _____

The form can either be signed traditionally and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.

Print Clear

Return your completed form by fax or mail to MassHealth.

Fax: (617) 988-8974

Mail: MassHealth Provider Enrollment and Credentialing
PO Box 278
Quincy, MA 02171-0278

If you have any questions about the enrollment process, please email PEC@Maximus.com. For general questions, you may contact MassHealth by email at provider@masshealthquestions.com. Please note: These email boxes are only for general questions. They are not secure. Please do not send documents to these email boxes, or include any personal health information (PHI) or personally identifiable information (PII). You may also call (800) 841-2900, TDD/TTY: 711.