

## Instructions For PROMISE™ Provider Practice Relocation Request

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This form can ONLY be used for the following Provider Types:

05 – Home Health Agency*	19 - Psychologist
06 – Hospice*	20 - Audiologist
09 – CRNP**	23 - Nutritionist
14 - Podiatrist	27 – Dentist
15 - Chiropractor	31 - Physician
16 - Nurse	32 - CRNA
17 - Therapist	33 - CNM
18 - Optometrist	

\* Provider type 05 and 06: CMS must have completed your address change in the PECOS system **before** you submit this form to provider enrollment

\*\*Provider type 09: You MUST provide a collaborative practice agreement reflecting change of address.

All sections must be completed in full; if left blank, application will be rejected.

### This form MAY be used for the following purposes only:

1. To update your *Service Location* address if the practice has *relocated* (please refer to example below).  
**Example of when to use this form:** The practice was located at 200 West Mills Street. The practice closed at 200 West Mills Street completely and relocated to 35 East Main Street.
2. To change a *Mail-To* address in conjunction with the relocation.
3. To change a *Pay-To* address in conjunction with the relocation.
4. To change a *Home Office* address in conjunction with the relocation.

### This form CANNOT to be used to ADD an address or make changes to a current service location:

1. To update your *Service Location* address if you changed employers (please refer to example below).  
**Example of when NOT to use this form:** If you were employed with a practice at 100 Fairfield Drive and you left this employer and are now working for a new employer at 4350 Fowler Street.
2. If this is your situation, you **MUST** do the following:
  - a) Submit a completed Provider Enrollment Application and any required related forms to add the new address:  
<http://www.dhs.state.pa.us/provider/promise/enrollmentinformation/index.htm>
  - b) Submit a **Provider Service Location Change Request to close the old address**  
[http://www.dhs.state.pa.us/cs/groups/public/documents/form/s\\_001983.pdf](http://www.dhs.state.pa.us/cs/groups/public/documents/form/s_001983.pdf)

Please submit these requests to:

DHS Provider Enrollment  
PO Box 8045  
Harrisburg, PA 17105-8045

- or -

Fax: (717) 265-8284

- or -

Email: [RA-ProvApp@pa.gov](mailto:RA-ProvApp@pa.gov)

## PROMISe™ Provider Practice Relocation Request

**THIS FORM CANNOT BE USED TO ADD A NEW SERVICE LOCATION OR MAKE CHANGES TO A CURRENT SERVICE LOCATION.**

This form can only be used to:

- Update the Service Location address if the practice has **RELOCATED**. See example on instruction sheet.
- Change the Pay-To, Mail-To, and/or Home Office address in conjunction with the relocation.

Please note: **You must complete a new Provider Enrollment Application to add a new service location where actual recipient services are provided.**

### **Old Address:**

The following address is the address listed currently for this service location:

Provider Name: _____	
PROMISe™ Provider Number: _____	(13 digits)
Provider Type Number and Description: _____ / _____	
Specialty Number and Description: _____ / _____	
Street Address: _____	
City: _____	County: _____
State: ____	Zip Code: _____ - _____

### **New Address:**

The address listed below is the address of the service location now:

Provider Name: _____	
Street Address: _____	Room/Suite: _____
City: _____	State: ____ Zip Code: _____ - _____
Phone No.: (____) _____	County: _____
Fax No.: (____) _____	Effective Change Date: ____/____/____
(1) Does the office have exterior or interior steps leading to the main entrance doorway? Yes <input type="checkbox"/> No <input type="checkbox"/> Exterior <input type="checkbox"/> Interior <input type="checkbox"/>	
(2) If the answer to (1) is yes, does the office have a permanent or portable wheelchair ramp? Yes <input type="checkbox"/> No <input type="checkbox"/> Permanent <input type="checkbox"/> Portable <input type="checkbox"/>	
(3) If the answer to (1) is yes, is there an alternate entrance that has no exterior or interior steps or has a wheelchair ramp? Yes <input type="checkbox"/> No <input type="checkbox"/> No exterior steps <input type="checkbox"/> No interior steps <input type="checkbox"/> Permanent ramp <input type="checkbox"/> Portable ramp <input type="checkbox"/>	
Is this address an active Rural Health Clinic or FQHC?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you bill for a mobile unit from this location?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mobile Medical Unit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mobile Dental Unit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Check this block only if you wish your Medicare claims to crossover to this service location. <input type="checkbox"/>	
***Once enrolled, you can retrieve RAs from PROMISe™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.	

## PROMISE™ Provider Practice Relocation Request

Please complete to change the Mail-to, Pay-to and/or Home Office address for the new location.

Change the Current: Mail-To <input type="checkbox"/> Pay-To <input type="checkbox"/> Home Office <input type="checkbox"/> Effective Change Date: ____/____/____	
Address: _____ Room/Suite: _____	
City: _____	Email: _____
State: ____	Zip Code: _____
Phone No.: (____) _____	Fax No.: (____) _____
Change the Current: Mail-To <input type="checkbox"/> Pay-To <input type="checkbox"/> Home Office <input type="checkbox"/> Effective Change Date: ____/____/____	
Address: _____ Room/Suite: _____	
City: _____	Email: _____
State: ____	Zip Code: _____
Phone No.: (____) _____	Fax No.: (____) _____
Change the Current: Mail-To <input type="checkbox"/> Pay-To <input type="checkbox"/> Home Office <input type="checkbox"/> Effective Change Date: ____/____/____	
Address: _____ Room/Suite: _____	
City: _____	Email: _____
State: ____	Zip Code: _____
Phone No.: (____) _____	Fax No.: (____) _____

Verify your **IRS Address** below: **Note:** This is the address where your **1099 tax document** will be sent.

Address: \_\_\_\_\_ Room/Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Phone No.: (\_\_\_\_) \_\_\_\_\_ Fax No.: (\_\_\_\_) \_\_\_\_\_

**Contact** Name/Phone number: In case we have questions concerning this form.

Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Please **sign and date** form below:

\_\_\_\_\_

Date Print or Type Provider Name

Original Provider Signature (Signature Stamps Not Accepted)