



# Name, Address and Phone Number Changes

Check all that apply  ASTC  CAH  CMHC  CORF  ESRD  RHC  
 HHA  Hospice  Hospital  OPT  PXR  Home Services  
 Home Nursing  Home Nursing Placement  Home Services Placement

License Number \_\_\_\_\_ Medicare Number \_\_\_\_\_

Current/Prior Name \_\_\_\_\_

Current Address \_\_\_\_\_

Current City \_\_\_\_\_ IL Current ZIP Code \_\_\_\_\_

Medicare Fiscal Intermediary (for reimbursement)

Name of Intermediary \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

## New Information

Name of Entity \_\_\_\_\_

New Address \_\_\_\_\_

City \_\_\_\_\_ IL ZIP Code \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

## Miscellaneous Information

Phone Number (area code) \_\_\_\_\_ Fax Number (area code) \_\_\_\_\_

E-mail Address \_\_\_\_\_

Effective Date of Change \_\_\_\_\_

Signature of Administrator \_\_\_\_\_

Type Name of Administrator \_\_\_\_\_

**Form may be faxed to: 217-782-0382**

For IDPH use only

For IDPH use only - Letters

<input type="checkbox"/> Odie/Aspen	<input type="checkbox"/> 670	<input type="checkbox"/> CMS	<input type="checkbox"/> Intermediary
<input type="checkbox"/> Access LDB	<input type="checkbox"/> 3270	<input type="checkbox"/> IDPA	