

**ADDRESS Change:** Effective Date: \_\_\_\_\_

**AHCA:**

Agency Name: \_\_\_\_\_

License #: \_\_\_\_\_ NPI: \_\_\_\_\_ MC #: \_\_\_\_\_ MA #: \_\_\_\_\_  
(Medicare Provider #) (Medicaid Provider #)

Issue date: \_\_\_\_\_ Exp Date: \_\_\_\_\_  
(License)

New Address: \_\_\_\_\_ City: \_\_\_\_\_

Zip Code new (*include 4 last digits*): \_\_\_\_\_ + \_\_\_\_\_ County: \_\_\_\_\_

New Phone: \_\_\_\_\_ New fax: \_\_\_\_\_

Tax ID: \_\_\_\_\_ email \_\_\_\_\_ Web site: \_\_\_\_\_

Contact Person/Title: \_\_\_\_\_ % ownership: \_\_\_\_\_ Date: \_\_\_\_\_

SS #: \_\_\_\_\_ DOB: \_\_\_\_\_ State Born: \_\_\_\_\_ Country Born: \_\_\_\_\_

Add when to sent to AHCA (21 days in advance): Copy of Lease, Zoning Letter, Insurance certificate, \$ 25.00 check

***(Do not fax to us)***

Administrator Name: \_\_\_\_\_

After AHCA approval:

**Send to Palmetto/MA/CLIA** letter, and application

Incorporation Date: \_\_\_\_\_ Medicare # issue date: \_\_\_\_\_

Accreditation Body: \_\_\_\_\_ Date: \_\_\_\_\_ Expiration: \_\_\_\_\_

CLIA #: \_\_\_\_\_ DON: \_\_\_\_\_

Bank Name: \_\_\_\_\_ Bank Ph: \_\_\_\_\_

Bank Contact person: \_\_\_\_\_

Routing: \_\_\_\_\_ Account: \_\_\_\_\_

Bank Address: \_\_\_\_\_

Click bellow to email the form:

or fax to (305) 819-4064