

## Long-Term Services and Supports (LTSS) Provider Change Form

Provider name:					
Keystone First CHC IE	D:		PPID#:		TIN:
Contact person name	(please print clearly)	Phone	Fax		Email address
Authorizing signature Change will not be complet	(provider/office mated without signature.	anager)	Today's date	E	Effective date of change
PROVIDER CHANGI Provide complete information a change on your W-9, you	on. This request will be	e processed for Ke	ystone First Community s change form.	/ HealthChoices	(CHC). If any of these changes resu
Type of change (please c ☐ Adding an office locat ☐ Changing an office loc	ion	☐ Fax chang ☐ Name cha			☐ Phone number change ☐ Other (attach documentation)
PREVIOUS OFFICE INF	ORMATION		NEW OFFICE IN	FORMATION	
	ORMATION		Provider name	FORMATION	
Provider name	ORMATION			FORMATION	
Provider name Street address	State	ZIP	Provider name	FORMATION	State ZIP
Provider name Street address City		ZIP	Provider name Street address	FORMATION	State ZIP Fax
Provider name  Street address  City  Phone	State	ZIP	Provider name  Street address  City	FORMATION	
Provider name  Street address  City  Phone  Email	State Fax	ZIP	Provider name  Street address  City  Phone	FORMATION	
Provider name  Street address  City  Phone  Email	State Fax	ZIP	Provider name  Street address  City  Phone	Fax	
PREVIOUS OFFICE INF Provider name Street address City Phone Email BILLING LOCATION CH Street address 1 Street address 2	State Fax	ZIP	Provider name  Street address  City  Phone  Email	Fax	Fax  Email address

 $Please\ email\ the\ completed\ form\ to\ chcproviders@keystonefirstchc.com.$