CHANGE OF LOCATION REQUEST

FOR PROVIDERS. BY PROVIDERS.

HOME CARE HOME HEALTH HOSPICE

Please complete the information below regarding the change of location for your organization.
Please note:

- ☐ Home Health Agencies and Hospices Seeking Initial Medicare Certification
  - » If your 855A has been accepted by your Medicare Administrative Contractor (MAC) but the initial survey has not been conducted, you must contact your MAC for approval of a relocation
  - » Home Health Agencies and Hospices cannot relocate during the period of time from the date of their Initial Medicare Certification Survey and the assignment of their CCN by the RO without the RO's approval
- ☐ Medicare Certified Home Health Agencies and Hospices
  - » Submit an 855A form to report your change of location to your MAC
  - » Upon receipt of the "Information Change Approval" letter from the MAC or CMS Regional Office, please forward a copy to your Account Advisor

Legal Name: _____

DBA Name: _____

Federal Tax ID #: _____ CCN #: _____ NPI #: _____

Contact: _____ Email Address: _____

Phone: _____ Fax: _____

Effective Date for Relocation: _____

Old/Previous Physical Address:

Address: _____

City: _____ State: _____ Zip: _____

Current/New Address (check all that apply): ☐ Physical ☐ Mailing ☐ Accounting

Address: _____

City: _____ State: _____ Zip: _____

Attestation Statement:

I _____ , hereby certify that all of the information on this request by Accreditation Commission for Health Care is true and correct.
I certify the following:

- This change is in compliance with all ACHC standards, as well as state, federal, and local regulations.
- The applicable state licensing board has been informed of this change of location.
- This location follows the policies and procedures surveyed during the initial visit.

- The new physical location is open according to the posted hours of operation and is appropriately equipped.

Signature: _____ Date: _____

Title: _____

For ACHC Internal Use Only

ACHC Approval: _____

Date: _____ Company ID #: _____