DCF Credentialing

Provider Information Change Form

Any change in status must be reported in writing to ABH within thirty days.

PROVIDER NAME:

Type of Change (check the appropriate box)

☐ Change of physical address, telephone, and/or fax number
☐ Change of billing/mailing address, telephone, and/or fax number
☐ Change/add secondary address, telephone, and/or fax number
☐ Change of provider status (e.g., moved out of area, specialist,)
☐ Staff no longer with organization – remove from roster

Staff Name:

☐ Other:

Comments:

Physical Address

Street Address:
City:
State: Zip Code:
Telephone: Fax Number: Email:

Accounting/Billing Address —All providers who make changes to the Accounting/Billing address must submit a copy of the W-9 along with this form.

Street Address:
City:
State: Zip Code:
Telephone: Fax Number: Email:

Secondary Address

Street Address:
City:
State: Zip Code:
Telephone: Fax Number: Email:

Mail or fax the completed form to:

Advanced Behavioral Health
ATTN: DCF Credentialing Department
213 Court St. Middletown, CT 06457
Fax 860.920.4457

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