

# Provider Address Change Form

**Provider Name** \_\_\_\_\_  
(please print)

**Provider ID Number/Taxonomy Code** \_\_\_\_\_

**Physical Address** \_\_\_\_\_  
(Where services are provided)

\_\_\_\_\_  
(Post office box allowed ONLY as an addition to a street address)

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **ZIP+4** \_\_\_\_\_

**County** \_\_\_\_\_ **Phone Number** (Include area code) \_\_\_\_\_

**Mailing/Billing Address** \_\_\_\_\_

\_\_\_\_\_  
**City** \_\_\_\_\_ **State** \_\_\_\_\_ **ZIP+4** \_\_\_\_\_

**Phone Number** (Include area code) \_\_\_\_\_

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

**Note:** Before a change can be made in your provider file, we must have your original signature. A photo copied or stamped signature is unacceptable and the only signature valid for an individual practitioner is their own.

**Provider's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Mail this completed form to:**

**Medicaid Provider Enrollment Unit  
HP Enterprise Services  
P.O. Box 8105  
Little Rock, AR 72203-8105**