P.O. Box 240808
Anchorage, AK 99524-0808
907.644.6800
http://medicaidalaska.com

Alaska Medical Assistance
Update Provider Information Request

- Do not use this form to update a Tax ID. Please contact the Provider Enrollment Unit at 907.644.6800 for assistance.
- To change EFT information, please complete the Authorization Agreement for Electronic Funds Transfer (EFT) form.
- To change Billing Agent Information, please complete the Provider Information Submissions Agreement (PISA) form. Additional forms can be found at https://medicaidalaska.com/portals/wps/portal/DocumentsandForms.

Section A: Information on File
Complete this section for all requests.

1. Provider Name _____
   (as currently on file)
2. Alaska Medical Assistance ID _____
   (Are other Medicaid IDs affected by this change? Complete and sign a separate form for each ID.)
3. Effective Date of Change _____

Section B: Update Information
Complete only the information that needs to be updated.

1. Provider Name _____
   (attach legal documentation for a name change)
2. Doing Business As (DBA) Name _____
3. Service Location Address _____
   (Street address, NO PO Boxes for servicing location)
   Also Applies to: Mailing ☐ Publication/Distribution ☐
4. Phone Number (___)_____
   Applies to: Contact ☐ Fax ☐
5. Billing Address _____
   (The president, owner, CEO, CFO, shareholder of at least five percent, or other authorized representative must sign a group application to update this address.)
   Also Applies to: Mailing ☐ Publication/Distribution ☐
6. Taxonomy Code: add ☐ end ☐ _____

7a. Identifier _____
Choose identifier type: NPI ☐ DEA ☐ CLIA ☐ NCPDP ☐
(Attach documentation for identifier being added.)

7b. Identifier _____
Choose identifier type: NPI ☐ DEA ☐ CLIA ☐ NCPDP ☐
(Attach documentation for identifier being added.)

Section C: Change Affiliation(s)
Add or discontinue by filling out all information in the numbered field.

ADD Affiliations	Discontinue Affiliations
1. Effective Date _____ Alaska Medical Assistance ID _____	1. Effective End Date _____ Alaska Medical Assistance ID_____
2. Effective Date _____ Alaska Medical Assistance ID _____	2. Effective End Date _____ Alaska Medical Assistance ID_____
3. Effective Date _____ Alaska Medical Assistance ID _____	3. Effective End Date _____ Alaska Medical Assistance ID_____

Other:_____

Original Signature Required

Important Notice: Individual providers must sign this change form. Groups or entities require the signature of an authorized representative.

_____ _____
Signature Date

_____ _____
Signer's Printed Name Signer's Title