***A MINIMUM OF 60 DAYS PRIOR NOTIFICATION OF A CHANGE IN SERVICE LOCATION IS REQUIRED.**

Department of Health
Adult Mental Health Division

PROVIDER CONTACT CHANGE FORM

Agency Name:	Date:
Type of Service(s):	Contact Name & Telephone Number:

Action to: ☐ Add ☐ Change ☐ Close	Effective Date of Action: Reason for Action:

Physical Location Address Change (include 4-digit zip code extension)	
Old Location Address:	New Location Address:
Is the New Location Address the Agency's Primary Business Location? ☐ Yes ☐ No	If No, Primary Location is:
Is this a Mailing Address Change (including claims and payment)? ☐ Yes ☐ No If yes, to make changes in a new mailing address for claims and payment, please attach a letter with your organization's letterhead and executive staff signature, and submit along with this completed form. (Note: our system can accommodate only one mailing address per provider.)	
Old Telephone/Facsimile Number:	New Telephone/Facsimile Number:
Last Date Consumers will be seen at the Closed (Old) Location:	
Has this new physical location been added to your Agency's Existing Certificate of Liability Insurance (COLI)? ☐ Yes, attach a copy of COLI ☐ No	

_____ _____
Signatory Name/Title (Print) Date

Please mail this completed form and any attachments to:

State of Hawaii, Department of Health
Adult Mental Health Division
Attn: **Provider Relations**
P.O. Box 3378, Room 256
Honolulu, Hawaii 96801-3378

For AMHD Use Only
Date Received: _____
Service Coordinator Approval (when applicable) Initials: _____ Date: _____
PHAO Approval (Initials): _____ Date: _____
Comments: