Provider Enrollment Unit
Office of MaineCare Services
Department of Health & Human Services
11 State House Station
Augusta, ME 04333-0011
1-800-321-5557

Print Form

Reset Form

Provider Information Update Form

This form must be completed in it entirety to make changes to the state controller's vendor file.
Please submit this form prior to changing your address or business status, including ownership, name change etc.
Inaccurate or incomplete information ion our files will result in a delay in reimbursement

Check all that apply:

New Vendor	Address Change	Multi Address	Name Change	Contact Update	ID # Change
☐	☐	☐	☐	☐	☐

*=MUST BE COMPLETED TO PROCESS ONE NAME/ADDRESS PER FORM

MaineCare Billing Provider Number: _____ one # per a form

Social Security Number*	OR	Federal Taxpayer ID Number*
S#	Please fill in ONE.	E#
Individual or Sole Proprietor Business name in "DBA" field below.		Corporation Business name in "Name" field below.

Remit to Address Changes (not physical)

NEW:* Individual or Business Name	OLD: Old #
Name	Name
DBA or C/O	DBA or C/O
Address	Address
Phone #	Phone #

Physical Address Changes

Name	Name
DBA or C/O	DBA or C/O
Address	Address
Phone #	Phone #

Submitted By:

Have accounts receivable been transferred to new owners?

Date effective:

Signature*

Print Name or Title

Date* (within 3 months)

Agency Office Use:	
Contact Person Name & Title*	Phone
Date sent to MFASIS	MFASIS OK
File Type	