Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services
Consolidated Community Reporting Initiative
Provider Change/Closure Form

Instructions for PROMISe™ Provider Service Location Change Request for Consolidated Community Reporting Initiative Providers

This form can be used for the following purposes only:

1. To "close" an existing service location
2. To change the "Mail-To" address for an existing service location
3. To change the "Pay-To" address for an existing service location
4. To change the "Home Office" address for an existing service location
5. To change the "e-mail" address for an existing service location

This form **cannot** be used to add a service location

- To add a service location, complete a Consolidated Community Reporting Initiative Provider Enrollment Application, as applicable, and any required related forms.

Please return form to:

DHS/OMHSAS
Business Partner Support Unit
Commonwealth Tower 12th Floor
PO Box 2675
Harrisburg, Pennsylvania 17105-2675

or

This form may also be sent via email to: RA-PWSERVICES@pa.gov

Updated 07/01/2019

PROMISe™ Provider Service Location Change Request for Consolidated Community Reporting Initiative Providers
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This form cannot be used to add a new service location address

Please **close** the following service location on my provider file:

Provider Name: ____

PROMISe™ Provider Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ (13 digits)

Provider Type and Description: ___ ___ / ____

Provider Specialty and Description: ___ ___ ___ / ____________________________________

Effective Close Date: ____ / ____ / ________

Service location address: ____

City: __________________________ State: _____ Zip: ___________ County:_________________

Phone Number: (____) _____ - _______

Please **change** the following address for a previously established service location: (Mail-To, Pay-To, Home Office, or e-mail address only. You **cannot** add or change a service location address using this form)

Provider Name: ____

PROMISe™ Provider Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ (13 digits)

Change the Current: ☐ Mail-To ☐ Pay-To ☐ Home Office Effective change date: : ___/___/_____

Provider Type and Description: ___ ___ / ____

Provider Specialty and Description: ___ ___ ___ / ____________________________________

E-mail Address: ____

Street address: ____

City: __________________________ State: _____ Zip: ___________ County:_________________

Phone Number: (____) _____ - _______

____ ____ / ____ / ________

Print or Type Provider Name Date

____

Original Provider Signature (Signature stamps not accepted)