Facility Information Change Form

*Please use this form to notify ESRD Network 18 of personnel and/or facility **changes**.*

HealthInsight
ESRD ALLIANCE | NETWORK 18

Facility Name:		**Provider #:**
Person Completing Form:	**Date:**	**Phone #:**
General Facility E-mail		

Medical Director Name:		**MD's NPI #:**	**MD's UPIN:**
MD's Office Phone #:	**MD's Emergency Phone #:**	**MD's Email Address:**	
MD's Office Fax#:	**MD's Office Address**	**City**	**State Zip Code**

Job Title	Name and Degree / Credentials	Emergency Phone	Email Address
Facility Administrator			
Master Account Holder			
Clinic Manager/Head Nurse			
Infection Control Manager			

Job Title	Name and Degree / Credentials	Email Address
Social Worker		

Area Manager Name	Phone #:	Fax #:	E-mail Address
Regional VP Name	**Phone #:**	**Fax #:**	**E-mail Address**

*The following changes **MUST** be reported to CMS. Please attach copy of CMS's acknowledgement/approval letter.

***Change of physical address** **Address** **City** **State** **Zip Code**	**Phone #**
☐ **Mailing Address (Check box if same as physical address)** **Address** **City** **State** **Zip Code**	**Fax #**

***Facility/Provider Legal Name**	
***Facility/Provider Doing Business As Name**	
***Ownership**	
***Licensed Stations / Isolation Stations**	
***New Services (e.g. HD, CAPD, PD, CCPD, etc.)**	
Shifts / Days / Times	

☐ **I certify that the above changes have been updated in CROWNWeb.**

Signature:_____ **Title:**_____ **Date:** _____

This form must be signed by the Medical Director, Facility Administrator or Clinic Manager.

Fax form back to the Network at 888-280-8669