



Facility Information Change Form

Only use this form to notify ESRD Network 18 of personnel and/or facility changes. **Fax it directly to: (323) 962-2891**

Facility Name:	Provider #:
Person Completing Form:	Phone: ()

Personnel Change(s)	Previous Personnel	New Personnel or Name Correction/Degree Status	Emergency Phone #	Email Address
<input type="checkbox"/> Medical Director				
<input type="checkbox"/> Administrator				
<input type="checkbox"/> Clinic Manager				
<input type="checkbox"/> Disaster Coordinator				
<input type="checkbox"/> Alt. Disaster Coordinator				

Personnel Change(s)	Previous Personnel	New Personnel or Name Correction/Degree Status
<input type="checkbox"/> Data Contact		
<input type="checkbox"/> Dietitian		
<input type="checkbox"/> Social Worker		
<input type="checkbox"/> Vascular Coordinator		
<input type="checkbox"/> Facility Voting Representative		
<input type="checkbox"/> Facility Voting-Alternate		

	Please utilize this section for new and/or corrected information.
<input type="checkbox"/> Provider Number (<i>Attach CMS Documentation</i>)	
<input type="checkbox"/> Provider Name	
<input type="checkbox"/> Address	
<input type="checkbox"/> City, State, Zip Code	
<input type="checkbox"/> (Area Code) Telephone Number	
<input type="checkbox"/> (Area Code) Fax Number	
<input type="checkbox"/> Licensed Stations (<i>Attach CMS Documentation</i>)	
<input type="checkbox"/> New Services (e.g. PD, Home Hemo) (<i>Attach CMS Documentation</i>)	
<input type="checkbox"/> Ownership	
<input type="checkbox"/> Management Affiliation	
<input type="checkbox"/> New Facility Certification (<i>Attach CMS & DHS Documentation</i>)	
<input type="checkbox"/> Closing Facility (<i>Attach letter specifying close date</i>)	

Other (*Please describe*): _____

Signature: _____ Date: _____