



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
<input type="checkbox"/> Medical Director			
<input type="checkbox"/> Data Contact			
<input type="checkbox"/> Administrator			
<input type="checkbox"/> Clinic Manager			
<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: _____