

Change Of Information

To update our records and to keep your payments coming, it is necessary to fill out a change of address form.

If you wish to change your name, you must fill out a new W-9 (with your new name) and provide supporting documentation such as a **copy** of a driver's license, marriage or divorce certificate. **NOTE**: **Only** providers billing under their social security number may use this form.

As per the Office of State Accounting, Vendor Compliance Section, providers billing under a tax identification number rather than their social security number must submit a change of address request on their company letterhead. If this is a name change, we will need a form W-9 filled out with the new name as well as a letter from the Internal Revenue Service associating the tax identification number with the new name.

For your convenience, a sample address change letter has been provided.



Ohio Department of Mental Retardation and Developmental Disabilities

Ted Strickland, Governor

John L. Martin, Director

CHANGE OF INFORMATION

Provider Name _____

(IF this is a name **change**-we will need a new W-9 and supporting documentation such as a copy of a driver's license, marriage or divorce certificate, or social security card. Please note the old name as well.)

MR/DD Contract Number _____

Social Security Number _____

(Note: This form can **only** be used by vendors billing under their social security number. Vendors using a tax identification number must submit requests for change of information on their company letterhead.)

E-Mail _____

Previous address _____

Previous phone (_____) _____ - _____

New address _____

Is this your mailing address? yes no *If no please indicate the address you wish your mail to go to.*

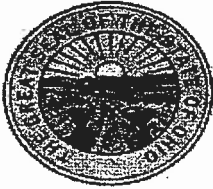
New Phone (_____) _____ - _____

Signature _____ Date _____

Submit completed form to:

ODMR/DD, Medicaid Payment & Support
Division of Fiscal Administration
30 E Broad St 13th Floor
Columbus OH 43215-3434

Fax 614.466.7359



STATE OF OHIO - OFFICE OF BUDGET & MANAGEMENT

30 E. BROAD STREET, 34th FLOOR

COLUMBUS, OHIO 43215 - 3457

<http://www.obm.ohio.gov/>

VENDOR INFORMATION CHANGE FORM

(Replaces the old CAS VENM Form)

ALL parts of this form must be completed by the vendor and returned to the issuing state agency

CHANGE OF INFORMATION ADD INFORMATION W-9 ATTACHED

COMPLETE VENDOR LEGAL BUSINESS NAME (Should match W-9)	
Business Name, Trade Name, Doing Business As: (If different from above)	
TAXPAYER ID # (TIN): <input type="checkbox"/> SSN <input type="checkbox"/> FEIN #	
TYPE OF ACTION:	
<input type="checkbox"/> Name Change (W-9 Attached) <input type="checkbox"/> TIN Change (Contact Agency) <input type="checkbox"/> Additional Address	
<input type="checkbox"/> Change in Payment Terms <input type="checkbox"/> Change in Purchase Order Dispatch Method	
<input type="checkbox"/> Change of Address <input type="checkbox"/> Change of Contact <input type="checkbox"/> Other (Specify)	
PLEASE EXPLAIN:	
IS YOUR BUSINESS CURRENTLY CERTIFIED AS <input type="checkbox"/> MBE (Minority Business Enterprise) <input type="checkbox"/> EDGE (Encouraging Diversity, Growth & Equity)	
PAYMENT TERMS: (Pick one only) <input type="checkbox"/> 2/10 Net 30 <input type="checkbox"/> Net 30	
AREA CODE & TELEPHONE NUMBER:	E-MAIL ADDRESS:
TYPE OR PRINT NAME OF PERSON COMPLETING THIS FORM	Signature

ADD ADDITIONAL BUSINESS ADDRESS, E-MAIL & CONTACT INFORMATION ON SEPARATE SHEET IF REQUIRED

PLEASE SEND COMPLETED FORM & QUESTIONS ABOUT THE FORM TO THE ISSUING AGENCY (information listed below):

ISSUING AGENCY INFORMATION Michelle Kessler Medicaid Payment and Support 30 E. Broad Street, 13th Floor Columbus, Ohio 43215
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