

# CHANGE OF CONTACT

Use this form to update contact information for the J15 Provider Audit & Reimbursement Department only. Please email the completed form to:

- Part A: [j15star@cgsadmin.com](mailto:j15star@cgsadmin.com)
- HHH: [j15cracceptance@cgsadmin.com](mailto:j15cracceptance@cgsadmin.com)

*To update a facility address, you must submit a CMS 855A enrollment application (online in PECOS or mail a paper form to Provider Enrollment).*

## PROVIDER INFORMATION

*Please print or type in each field.*

Provider Number (6-digit PTAN):

Provider Name:

## MAIN CONTACT

*CGS will mail correspondence related to cost reports and reimbursement information to this person's attention.*

Contact Name:

Title:

Email:

Street Address:

City, State, ZIP Code:

Phone Number:

Fax Number:

## FQHC/RHC PROVIDERS ONLY

**Cost Report Filing Information** (Please check one):

This facility will file a separate and independent cost report.

This facility will file one consolidated cost report with its related facilities under provider number (6-digit PTAN):

Associated with MAC number/name:

Approved by:

**Note:** An administrator or authorized official should approve the completed form.

Date: