GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES
Department of Human Services
"Working Together to Make a Difference"

Medical Assistance Program

VI Medicaid Program Provider Enrollment
Department of Human Services
1303 Hospital Ground
Knud Hansen Complex, Bldg. A
St. Thomas, USVI 00802

Change of Address

External Form USVI

Medicaid Provider:

Please complete this change of address form to document a change of address, whether mailing or physical. Read each question carefully before completing this form to eliminate the possibility of error. <u>This form must be returned with an original</u> <u>signature</u> to VI Medicaid Program Provider Enrollment, Department of Human Services, 1303 Hospital Ground, Knud Hansen Complex, Bldg. A, St. Thomas, USVI 00802

PROVIDER NUMBER AND EFFECTIVE DATE

Provider NPI :			**Change of Address Effective Date:**	

PHYSICAL LOCATION ADDRESS

Provider Name: (individual or facility name)			
DBA:			
Address 1:			
Address 2:			
City, State Zip:			
Phone: (include area code)		**Fax:** (include area code)	
E-mail:			
County: (of physical location)			

MAILING ADDRESS

Address 1:	
Address 2:	
City, State Zip:	
County: (of physical location)	

TAX IDENTIFICATION

Enter **either** the Federal Employer Identification Number (FEIN) ***<u>OR</u>*** the Social Security Number (SSN) under which your income is reported for Federal 1099 purposes.

☐ **FEIN:**		**<u>OR</u>**	☐ **SSN:**	

SIGNATURE

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Authorized Provider Representative Name Printed Title/Position

____ _________________________________

Authorized Provider Representative Signature Date