ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

REQUEST FOR CHANGES TO PROVIDER RECORD
TRANSMITTAL OF DOCUMENTS

Provider Name:_____

FEIN:_____

Document Name	Total # of Documents	Total # of Pages
Form 1 – Provider General Information		
Form 2 – Site Specific/Services Change Form		
Form 3 – NPI Change Form		
Totals		

Attestation:

The Agency certifies that all information provided with this submitted form to the Illinois Mental Health Collaborative for Access and Choice is true and correct to the best of the Agency's knowledge and that it is free of any significant misstatements, misrepresentations or omissions.

_____
Agency Name

_____ _____ / _____ / _____
Authorized Signature Date (mm/dd/yy):

_____
Name (Please Print)

_____
Title

Fax or mail your completed forms to your DMH Contract Manager or DMH Region Office.