DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PROVIDER TIE-IN NOTICE

(Addition, Deletion or Correction to the Intermediary List of Providers)

Date

NOTE: Intermediary should report any items requiring correction to the Health Insurance Regional Office.

I. Identifying Information *(Complete in all cases)*

A. Name of Provider	B. Provider Number
C. Address *(Street, City, State, Zip code)*	D. Effective Date of Certification

II. New Provider Certification

A. Fiscal Year Ending Date	B. Authorized Intermediary	C. Intermediary Number

Where Provider Certification Required because of a Change of Ownership—Also complete the following:

D. Effective Date of Change of Ownership	E. Facility's Name and Provider Number prior to Change of Ownership *(Write "Unchanged" if applicable)*	F. Certification Date of Previous Owner

G. Intermediary for Previous Owner *(If same as item IIB, write "Unchanged")*	H. Effective Date of Intermediary Change *(Complete where IIB & IIG differ)*

III. Change of Intermediary

A. Outgoing Intermediary	B. Intermediary Number	C. Provider's Fiscal Year Ending Date
D. Incoming Intermediary	E. Intermediary Number	F. Effective Date of Change of Intermediary

IV. Terminations

A. Check one ☐ Voluntary ☐ Involuntary	B. Effective Date of Termination	C. Servicing Intermediary	D. Intermediary Number

V. Remarks *(If this notice corrects a previous notice, indicate date of the notice and the item(s) reported incorrectly)*

Authorizing Officer	Title	Regional Office

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