DEPARTMENT OF HEALTH/DDSD
PROVIDER AGREEMENT AMENDMENT

THIS IS A LEGAL BINDING DOCUMENT WHICH REQUIRES ORIGINAL SIGNATURES.
PLEASE PRINT CLEARLY. THOSE THAT ARE ILLEGIBLE WILL BE RETUNED.

PROVIDER INFORMATION - All sections must be completed.		
Provider Name:	**Contact Person:**	
Provider Address:	**Telephone Number:**	**Facsimile Number:**
	E-Mail Address:	**Medicaid Billing #**:

AMENDMENT INFORMATION

☐ **EXTEND PROVIDER AGREEMENT TERM FROM**

***Providers may not add or delete existing services, Waiver or counties for amendment extensions.**

LIST SERVICE(S); ✓ADD or DELETE; ✓ WAIVER (DD, MF or Supports Waivers) ✓ RO Notified and LIST COUNTY(IES) *See information below.

List Service(s)	Add	Delete	DD	MF	SW	* RO Notified	List County(ies)
1.							
2.							
3.							
4.							
5.							

See reverse side or second page of the form to add more services and/or counties.

AUTHORIZED SIGNATURES

All terms of initial authorized Medicaid Waiver Provider Participation Agreement shall remain in effect.

Authorized **Provider** Signature	Date	**DD DOH**/Authorized Signature	Date

When expanding outside your current region and/or current services, please submit Program Descriptions for the service(s) you want to add. (See DD and/or MF Service Standards). Attach all necessary credentials such as but not limited to: Professional licensure, degrees, resumes, and/or transcripts.

Please mail ORIGINAL Amendment Form to:
ATTN: Tammy M. Barth
NMDOH/DDSD/PEU
PO Box 26110,
Santa Fe, NM 87502-6110

ORIGINAL – DDSD **COPY – Provider**

Revised 3.2020

AMENDMENT INFORMATION CONTINUATION

LIST SERVICE(S); ✓ADD or DELETE; ✓ WAIVER (DD, MF or Supports) ✓ RO Notified and LIST COUNTY((IES)

List Service(s)	Add	Delete	DD	MF	SW	* RO Notified	List County(ies)
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