Provider Contact Change Form

Cotiviti is a Recovery Auditor for CMS. While providers should always keep their contact information current with their Medicare Administration Contractor (MAC) as well as the National Provider Information (NPI) Registry, the contact information below will help ensure RAC-related information from Cotiviti is addressed appropriately to avoid unnecessary denials based on non-receipt.

Instructions

Instead of this form, the same changes can also be made online through the Cotiviti Provider Portal at www.Cotiviti.com/RAC

1. This form must be completed and submitted electronically therfore, printing is disabled – do not fax or mail.
2. Once all sections are completed, please double-check it for accuracy. **Note:** Only one contact is permitted per address type, and this change form cannot be processed without the required fields in Section A.
3. Save the completed form to your computer with the provider name and current date as the document name (e.g. GraceHealthcare_04042016)
4. Attach the form to an email and send to RACInfo@Cotiviti.com with 'Contact Change Form' in the subject. Your change will be processed within 2 business days.
5. **Note:** If you represent multiple facilities/providers, please use the 'Multi-provider Spreadsheet' found at the above web address – rather than submitting multiple copies of this form.

A. Required Information

Provider Name:____ Provider Medicare ID:____________________

Tax Identification Number: __________________________ NPI Number: ___________________

*Person Submitting this form: ___________________ Phone Number for any Questions: ____________________

B. Contact for Medical Records

This is where Additional Documentation Requests (ADR) will be mailed, and courtesy reminders faxed.

Contact Person (to the attention of): __________________________________ Title: _____________________

Address Line 1:____ Phone:______________________

Address Line 2:____ Fax: ______________________

Address Line 3:____ Email:______________________

City:__________________ State:____ Zip Code: _______

C. Contact for Finance

This is where review results letters and reimbursement checks (if applicable) will be mailed.

Check here to use same info as Section B.

Contact Person (to the attention of): __________________________________ Title: _____________________

Address Line 1:____ Phone:______________________

Address Line 2:____ Fax: ______________________

Address Line 3:____ Email:______________________

City:__________________ State:____ Zip Code: _______

D. Facility Location

This is the physical location of the facility/provider.

Check here to use same info as Section B.

Contact Person (to the attention of): __________________________________ Title: _____________________

Address Line 1:____ Phone:______________________

Address Line 2:____ Fax: ______________________

Address Line 3:____ Email:______________________

City:__________________ State:____ Zip Code: _______

E. Discussion Response

Check here to use same info as Section B.

Contact Person (to the attention of): __________________________________ Fax: _____________________

Note: If Section E is completed, the response to any Discussion Requests will automatically be faxed to this contact. If the fax attempt is unsuccessful, it will automatically drop to mail by default to the contact in Section C.

*By submitting this form, the person named in Section A acknowledges they are authorized to request these changes on behalf of the facility.