# 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 #:** |

## EXTENSIONS

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

☐ **EXTEND PROVIDER AGREEMENT TERM FROM**

## ADDITIONS / DELETIONS

**SERVICE(S); ✓ADD or ✓DELETE; ✓ WAIVER (DD, MF or SUPPORTS); COUNTY(IES) *See information below.**

| Service(s) | Add | Delete | DD | MF | SW | County(ies) |
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## AUTHORIZED SIGNATURES

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

**Authorized Provider Signature** **Date** **Provider Enrollment Manager Signature** **Date**

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

*When expanding outside your current region and/or adding a service, please submit necessary policies and additional program description questions for the service(s) you want to add, including all necessary credentials such as but not limited to professional licensure, degrees, resumes, and/or transcripts.

**ORIGINAL – DDSD** **COPY – Provider**

Revised 11.2022

## AMENDMENT INFORMATION CONTINUATION

### ADDITIONS / DELETIONS

### LIST SERVICE(S) ✓ADD or ✓DELETE; ✓ WAIVER (DD, MF or SUPPORTS); LIST COUNTY(IES)

| Service(s) | Add | Delete | DD | MF | SW | County(ies) |
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