ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

REQUEST FOR CHANGE TO DHS/DMH PROVIDER RECORD

FORM 1 – ADMINISTRATION INFORMATION

NOTE 1: Adobe Reader or Adobe Pro is REQUIRED. (Please download free Adobe Reader here)

NOTE 2: Fields with red square around and marked with *, are REQUIRED fields.

Provider Information

Provider Name*:

FEIN*:

Changes are effective on*:

UEI:

NPI*:

Administrative Office Information

Legal Name*:

DBA Name (If different from legal name):

Mailing Address 1*:

Mailing Address 2:

City*:

State IL Zip*:

Administrative Contact*:

Contact Phone*:

Website*:

Contacts Email*:

Primary Contact Persons

	Name	*Email*	*Phone*
CEO*:			
CFO:			
CMO:			
CCO:			
CIO:			
BM:			

Owner Information

Ownership Type*: ☐ Public ☐ Private

Status*: ☐ For Profit ☐ Not-for-Profit ☐ Neither ☐ Gov't Program (Fed, State, County, City)

Owner Name:

Mailing Address 1:

Mailing Address 2:

City:

State: IL Zip:

Board of Directors Information

Board President:

President Phone:

RESET

DO NOT WRITE IN THIS AREA – FOR OFFICIAL USE ONLY

Region

Reviewer Name