



Send completed form and attachments by fax or email to the following:

CMS Provider Management

Fax: (850) 487-1279

Email: cmsproviderhelp@doh.state.fl.us

Provider Name Change Form

Current Name

Please type your name as it currently appears in the Provider Management System

Last	
First	
Middle	

New Name

Please type your new name exactly as you would like it to appear in the Provider Management System, including hyphens, apostrophes, etc.

Last	
First	
Middle	

REQUIRED: Please attach a copy of your Marriage License, Divorce Decree or other legal documentation as proof of identification and submit with this form.

My signature authorizes CMS Provider Management to update my current credentialing application to reflect the above change to my legal name.

Provider Signature _____

Date: _____