# Provider Information Update Form

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

**CMS Provider Management**
**Fax:** (850) 487-1279
**Email:** cmsproviderhelp@floridahealth.gov

## 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, driver's license, medical license or other legal documentation as proof of identification and submit with this form.**

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

**Provider Signature:** _____ **Date:** _____

**License#:** _____ **NPI#:** _____