



# Name and Address Change Form

Please complete and sign this form and return it to the Provider Credentialing Team at [wdh-hcbs-credentialing@wyo.gov](mailto:wdh-hcbs-credentialing@wyo.gov). Please select No Change if a change isn't being made to a section.

Date:
Provider NPI/Wyoming #
Provider Name, as currently certified:

<b>Name Change</b>		<input type="checkbox"/> No Changes
Last:	First:	
Business Name:	<input type="checkbox"/> N/A	

<b>Address Change</b>		<input type="checkbox"/> No Changes
Street Address:		
PO Box:		
City:	State:	Zip:
<input type="checkbox"/> Physical		<input type="checkbox"/> Mailing
Street Address:		
PO Box:		
City:	State:	Zip:
<input type="checkbox"/> Physical		<input type="checkbox"/> Mailing

<b>Email Address Change</b>		<input type="checkbox"/> No Changes
Email Address:		

<b>Phone Number Change</b>		<input type="checkbox"/> No Changes
Phone Number:		
<input type="checkbox"/> Mobile	<input type="checkbox"/> Home	<input type="checkbox"/> Business

<b>Other Changes</b>		<input type="checkbox"/> No Changes

Provider Signature \_\_\_\_\_ Date: \_\_\_\_\_

Division Use Only

Changes entered into IMPROV

Provider Credentialing Specialist \_\_\_\_\_ Date: \_\_\_\_\_