

Notification of DSDHH RFA Information Change

In accordance to Article 4.22 of the Contract, I hereby notify DSDHH of the following change(s). **Personnel changes must be submitted and on file with DSDHH prior to a new employee certifying and / or fitting applicants for EDS hearing aid assistance. Complete all sections as appropriate to your notification.**

Date of Notification _____

Business Name and Address of Provider: (as submitted on Attachment B of RFA)

Person Submitting Information: _____
(Print Name)

(Signature) Date _____

Provider Tax I.D. Number: _____

I. ADDITION / DELETION OF STAFF ___ ADD ___ DELETE

Name: _____

If addition – Complete the following:

Office Location Assigned: _____

Start Date of New Employee: _____

Staff Person is licensed in the State of North Carolina to dispense hearing aids?
_____ Yes _____ No

(PROOF OF LICENSURE MUST BE SUBMITTED WITH SIGNED AUDIOLOGIST AND HEARING INSTRUMENT SPECIALIST VERIFICATION FORM AT TIME OF NOTIFICATION)

II. CHANGE OF BUSINESS ADDRESS OR OFFICE ___ ADD ___ DELETE

DBA Name of Office (if applicable) _____

Address of Office Location _____

This Office is: ___ New Purchase ___ Closure ___ Address Change

If closure, is office: ___ Relocated ___ Permanent Closure (must contact DSDHH)

III. Change of TAX IDENTIFICATION NUMBER (New W-9 must be submitted with Notification)

Old Provider Name (as registered) W-9 Number _____

New Provider Name (if applicable, as registered) New W-9 Number _____