

**HOME MEDICAL EQUIPMENT PROVIDER**

**REQUEST TO AMEND LICENSE FOR CHANGE OF NAME AND/OR ADDRESS**

Under the authority of chapters 400, Part VII and 408, Part II, Florida Statutes (F.S.) and chapters 59A-25 and 59A-35, Florida Administrative Code (F.A.C.), this notification is being submitted for a new license due to the pending change of name and/or address of a home medical equipment (HME) provider.

59A-35.040, F.A.C., requires any request to change the address of record of a home medical equipment provider license be received by the Agency 21 to 120 days in advance of the requested effective date. All other requests to amend a license including change of name must be received 60 to 120 days in advance. 59A-35.040, F.A.C., further states, “Failure to submit a timely request shall result in a $500 fine.”

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| **(1)** **HOME MEDICAL EQUIPMENT PROVIDER’S *CURRENT* INFORMATION** | | | | | | | | | |
| HME License # | Federal Employer Identification # | National Provider Identifier (NPI) | | | CMS CCN (Medicare #) | | | Medicaid # | |
| Name of Provider | | | | | | Telephone Number | | | |
| Street Address | | | | | | Fax | | | |
| City | | | County | | | State | | | Zip Code |
| Mailing Address *(if different from current street address above)* | | | | | | | | | |
| City | | | | State | | | Zip Code | | |

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| **(2) HOME MEDICAL EQUIPMENT PROVIDER’S *NEW* INFORMATION (enter all that will change from above)** | | | | | |
| Name of Provider *(Note: A name change requires revised filing with the Florida Division of Corporations.)* | | | Telephone Number | | |
| Street Address *(Note: An address change may require updated filing with the Florida Division of Corporations.)* | | | Fax | | |
| City | County | | State | | Zip Code |
| E-mail Address | | | | | |
| Mailing Address *(if different from new street address above)* | | | | | |
| City | | State | | Zip Code | |

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| **(3)** **EFFECTIVE DATE OF CHANGE AND REQUIRED SUPPORTING DOCUMENTATION** |
| State the date of name change and/or relocation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and enclose the following:  Proof of compliance with applicable Florida Department of State filing requirements  Proof of current commercial and professional liability insurance coverage in the new name and/or address  Copy of medical oxygen retail establishment permit and/or accreditation documents reflecting name and/or address change, if applicable *(If the provider is currently exempt from Agency survey, submit a copy of the new medical oxygen retail establishment permit and/or documentation of the accrediting organization’s acceptance of the change.)*  Proof of compliance with local zoning requirements *(proof must be issued by local zoning authority stating that the location is zoned appropriately for a home medical equipment provider – business tax receipt will not suffice) –* *address change only*  Proof of legal right to occupy the property (deed, lease including landlord/tenant signatures, etc.) – *address change only* |

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| **(4) FEE FOR PROCESSING CHANGE AND ISSUING NEW LICENSE** | **Fee enclosed:** |
| **Change of Name and/or Address**  *Please make check or money order payable to the Agency for Health Care Administration (AHCA).* | **$25.00** |

**RETURN THIS COMPLETED FORM WITH THE FEE TO:**

AGENCY FOR HEALTH CARE ADMINISTRATION

HOME CARE UNIT

2727 MAHAN DR MS 34

TALLAHASSEE FL 32308-5407

**Questions?** Review information at [ahca.myflorida.com](http://ahca.myflorida.com)/homecare or contact the Home Care Unit at (850) 412-4403.