



Hennepin Health

LOCATION ADD/CHANGE FORM

Complete this form when adding a location, relocating a location, closing a location or updating demographic information.

- Complete 1 form per location.
- If the change is related to the FEIN (Tax ID) or Billing Address, a W-9 will need to be submitted with this form.
- If adding a location, please include a list of providers to affiliate to the new location.

Please fax completed form to **(612) 632-8830** or email to HHNetworkManagement@Hennepin.us

TYPE OF CHANGE: ADD CHANGE TERM Effective Date of Change: _____

OLD Information:

Legal Business Name: _____

Doing Business As (DBA): _____

FEIN (Tax ID): _____ NPI/UMPI: _____

Website: _____ Phone #: _____ Email: _____

Physical Address: _____

Mailing Address: _____ Same as Above

Billing Address: _____ Same as Above

NEW Information:

Legal Business Name: _____

Doing Business As (DBA): _____

FEIN (Tax ID): _____ NPI/UMPI: _____

Website: _____ Phone #: _____ Email: _____

Physical Address: _____

Mailing Address: _____ Same as Above

Billing Address: _____ Same as Above

Is the location actively enrolled as a Minnesota Health Care Programs (MHCP) provider? No Yes

Access and Accessibility:

Hours of Operation
(e.g.; 9 am – 5 pm)

Sunday _____
Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday _____
Saturday _____

Walk-in/Urgent Care hours N/A

Sunday _____
Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday _____
Saturday _____

Is this location wheelchair accessible? No Yes N/A

Is transfer assistance available? No Yes N/A

Are private waiting areas available? No Yes N/A

What is the approximate distance from this location to public transportation?

- 1-2 blocks
- 3 to 5 blocks (1/4 mile)
- 6 to 8 blocks (1/2 mile)
- 9 to 10 blocks (3/4 mile)
- 11-13 blocks (1 mile)
- More than 2 miles to public transportation

Is the exam room large enough for assistive equipment? No Yes N/A

Languages Spoken at Location _____

Publish location in Directory No Yes

Submission

Person completing form (Print Name): _____ Date: _____

Title: _____ Signature: _____

Email: _____ Phone #: _____