DEPARTMENT OF HEALTH/DDSD
PROVIDER AGREEMENT AMENDMENT

THIS IS A LEGAL BINDING DOCUMENT WHICH REQUIRES ORIGINAL SIGNATURES.
PLEASE PRINT CLEARLY. THOSE THAT ARE ILLEGIBLE WILL BE RETURNED.

PROVIDER INFORMATION - All sections must be completed.		
Provider Name:	**Contact Person:**	
Provider Address:	**Telephone Number:**	**Facsimile Number:**
	E-Mail Address:	**Medicaid Billing #:**

EXTENSIONS

***Providers may not add or delete existing services or counties for amendment extensions**

☐ **EXTEND PROVIDER AGREEMENT TERM FROM**

ADDITIONS / DELETIONS

SERVICE(S); ✓ADD or ✓DELETE; ✓ WAIVER (DD, MF or SUPPORTS); COUNTY(IES) *See information below.

Service(s)	Add	Delete	DD	MF	SW	County(ies)
1.						
2.						
3.						
4.						
5.						

AUTHORIZED SIGNATURES

***All terms of initial authorized Medicaid Waiver Provider Participation Agreement shall remain in effect.**

Authorized Provider Signature **Date** **Provider Enrollment Manager Signature** **Date**

Please email Amendment Form to:
ATTN: Tammy M. Barth
Tammy.Barth@doh.nm.gov

*When expanding outside your current region and/or adding a service, please submit necessary policies and additional program description questions for the service(s) you want to add, including all necessary credentials such as but not limited to professional licensure, degrees, resumes, and/or transcripts.

ORIGINAL – DDSD **COPY – Provider**

Revised 9.2023

AMENDMENT INFORMATION CONTINUATION

ADDITIONS / DELETIONS

LIST SERVICE(S) ✓ADD or ✓DELETE; ✓ WAIVER (DD, MF or SUPPORTS); LIST COUNTY(IES)

Service(s)	Add	Delete	DD	MF	SW	County(ies)
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