Alabama Medicaid Agency
Change of Ownership Information
Reporting Change of Ownership Information

Medicaid requires the owner of a Medicaid-enrolled facility to report any change of ownership to Medicaid as soon as Medicare has been notified. A provider's enrollment must be active and in good standing to complete a change of ownership.

Providers who accept the previous owner's Medicaid agreement must complete the change of ownership form and submit a new Electronic Funds Transmittal (EFT) Form, W-9, and Disclosure Forms for any owners, officers, directors, agents, managing employees, and shareholders with 5% or more controlling interest. Also, please attach a brief statement of the course of action you are pursuing. The completed above mentioned documentation must be mailed to the Enrollment & Sanctions Unit, Program Integrity Division, Alabama Medicaid Agency, 501 Dexter Avenue, P O Box 5624, Montgomery, Alabama 36104.

Providers who do not accept the previous owners Medicaid agreement must complete a new application. To submit a new application, visit our website at www.medicaid.alabama.gov.

CHECKLIST

Please make sure all documents are attached.

_____ **Change of Ownership Form**

_____ **Disclosure forms** (*for any owners, officers, directors, agents, managing employees and shareholders with 5% or more controlling interest*.)

_____ **EFT**

_____ **W-9**

_____ **Sales Agreement**

_____ **Brief statement of the course of action being taken**

_____ **Other** _____

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This form is to be completed and returned to the Medicaid Agency as specified on previous page.

Currently enrolled providers who will experience a change in ownership or a change in tax number of a facility must complete the information below.

Effective or Anticipated date of change: _____

Reason for change: ☐ CHANGE OF OWNERSHIP ☐ MERGER ☐ OTHER_____

Previous Owner's Information

Facility Name _____

Alabama Medicaid Provider Number _____

NPI Number _____

Tax ID Number _____

Contact Name _____

Contact Telephone Number _____

The section below is intended for you to provide the information for any changes made as the result of the change of ownership (CHOW). Once the CHOW takes place the information you provide below will be reflected in our Alabama Medicaid Enrollment System. If the information is not changing, please indicate this as well.

New Owner's Information

Facility Name _____

NPI Number _____

Tax ID Number _____

Payee Address _____

Mailing Address _____

Contact Name _____

Contact Telephone Number _____

Contact Email Address _____

A copy of the sales agreement signed by all parties is required.

_____

Name of Authorized Representative (typed or printed legibly) Title

_____

Signature Date