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

Medicaid requires the owner of a Medicaid-enrolled facility or group to report any change of ownership (CHOW) to Medicaid within 30-days of the change or sale. Timely receipt of this information assists the Medicaid Agency in completing a provider’s CHOW. Please note that 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 the following documents: Electronic Funds Transmittal (EFT) Form; W-9; sales agreement/bill of sale; and Disclosure Forms for any owners, officers, directors, agents, managing employees, and shareholders with 5% or more controlling interest. Also, please attach a detailed statement of the course of action you are pursuing. The above mentioned forms are located on the Medicaid website at www.medicaid.alabama.gov in the Forms section under the Provider, Provider Enrollment tabs. The completed 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. If you are accepting the previous owner’s agreement, it is not necessary for you to complete an application.

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.

Note: For all hospital CHOWs, please indicate in your detailed statement and on the form below whether the hospital will be a public or private entity after CHOW completion.

For questions concerning CHOWs, please contact the Enrollment & Sanctions Unit at (334) 242-5141.

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 (Updates to EFT are not made by Medicaid until CHOW completion. Any EFT changes prior to CHOW completion to facilitate payment of funds directly to the new owner will have to be submitted via the Medicaid Interactive Web Portal by the old owner with agreement by the new owner.)

_____ W-9

_____ Sales Agreement or Bill of Sale

_____ Detailed 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 facility or group providers who will experience a change in ownership or a change in tax number 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 ____________________________________________________________

Public □ Private □ (for hospitals only—must check one)

NPI Number __________________________________________________________________

Tax ID Number __________________________________________________________________

Payee Address __________________________________________________________________

Mailing Address __________________________________________________________________

Contact Name __________________________________________________________________

Contact Telephone Number __________________________________________________________________

Contact Email Address __________________________________________________________________

Name of Authorized Representative (typed or printed legibly) Title

____________________________________________
Signature Date