

**Center for Health Information and Analysis
501 Boylston St, Boston MA, 02116
Main Tel: 617-701-8100 Fax: 617-727-7662 Help Desk: 617-701-8297**

Nursing Facility Rate Notification Contact Form

Facility Information

Facility Name (Doing Business As), if different:	
Provider ID	
Effective Date of Change in Provider ID	
Facility Street Address	
Facility City, State, ZIP Code	
Type of Change	<input type="checkbox"/> New <input type="checkbox"/> Change of Ownership <input type="checkbox"/> Change in Legal Form <input type="checkbox"/> Change in Rate Notification Contact
Legal Status	<input type="checkbox"/> MA Corp (Chap 156) <input type="checkbox"/> MA Corp (Chap 156 with 501c(3) exemption) <input type="checkbox"/> MA Non-Profit Corp (Chap 180) <input type="checkbox"/> Limited Liability Corporation (LLC) <input type="checkbox"/> Partnership / LLP <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Governmental Entity <input type="checkbox"/> Non MA Corp <input type="checkbox"/> Other For-Profit <input type="checkbox"/> Other Non-Profit
Federal Employer Identification Number (FEIN)	

Please complete the section below with the name, title, mailing address, phone number and email address of the person designated by the facility to receive rate reimbursement notifications.

Rate Contact Information

Contact Name	
Contact Title	
Mailing Street Address	
Mailing City, State, ZIP Code	
Contact Phone Number	
Contact E-mail Address	

Signature of Preparer

Date

Print Name of Preparer

Title