# Change or Correction Request Form*
## Office of Outpatient and In-Home Care Services
## Nebraska DHHS, Division of Public Health, Licensure Unit
## Print all Information

**Facility (doing business as) Currently-Approved Identification Information.**

**Facility License Type & Number:** _____
**(Required Field)**

**Facility Medicare Provider Number (CCN, 6-digit number):**_____
**(Required Field IF Medicare-certified)**

**Facility (doing business as) Name:** **(Required Field)**

_____

**Facility (doing business as) Physical Address:** **(Required Field)**

_____
**(Street Address City State Zip Code)**

**Request Type:** Change **or** Correction
**(Required Field – Circle One)**

****Request Effective Date (month/day/year):** _____
**Month Day Year (Required Field)**

**Description of CURRENTLY-APPROVED Information:** **(Required Field)**

**Description of NEW or CORRECTED Information Requested:** **(Required Field)**

### Authorizing Signature(s) (Required Fields)

**PLEASE NOTE – Neb.Rev.Stat. Section 71-433 requires: Applications shall be signed by (1) the owner, if the applicant is an individual or partnership, (2) two of its members, if the applicant is a limited liability company, (3) two of its officers, if the applicant is a corporation, or (4) the head of the governmental unit having jurisdiction over the facility to be licensed, if the applicant is a governmental unit."**

_____ _____
AUTHORIZED REPRESENTATIVE – TYPE OR PRINT SIGNATURE
DATE

_____ _____
AUTHORIZED REPRESENTATIVE – TYPE OR PRINT SIGNATURE
DATE

***Medicare-certified provider/suppliers MUST ALSO submit change/correction information directly to their Medicare Administrative Contractor. A separate form MUST BE submitted for each requested change or correction. Changes which terminate the license require submission of a complete initial licensure application.**

****For Administrator changes must include end date (month/day/year) for prior Administrator & include documentation with new Administrator's qualifications.**