Linkia Independent Change Request Notification

Email to RCMBilling@Hanger.com fax 512-201-6060 completed notification with applicable documentation.

Est. Change Date (if applicable): ______________________

☐ Acquisition ☐ Closure ☐ Change in Services (e.g. office hours, services etc.)

☐ Relocation ☐ Change in Billing (W9) ☐ Other: ______________________

Authorizing Request ______________________

First and Last Name *Title* *Email Address*

New Location Information

Additional documentation required: Copy of the facility's current accreditation (if issued), a copy of O&P facility license, Medicare, W-9, Certificate of Liability, Certification or Practitioner licenses as required.

Date Business Started at Location: ______________________

Office Info: ______________________

DBA Name

____

Legal Name *TIN*

Address: ______________________

Street Name and Number *Suite, Room, etc.*

____

City *State* *ZIP Code + 4*

Telecom: ______________________

Phone Number *Fax Number*

Accredited by: ______________________

Supplier #'s: ______________________

Medicare Supplier Number (PTAN) *NPI Number*

LINKIA
A Hanger Company

Hours of Operation

Monday__________to __________ **Friday** __________to ___________

Tuesday__________to __________ **Saturday**__________to ___________

Wednesday__________to __________ **Sunday** __________to ___________

Thursday__________to __________

Previous Location Information – *If APPLICABLE (Location is moving or merging)*

Date Business Ended at Location: ______________________________

Info: ____

DBA Name

____

Legal Name *TIN*

Address: ____

Street Name and Number *Suite, Room, etc.*

____

City *State* *ZIP Code + 4*

Telecom: ____

Phone Number *Fax Number*

Accredited by: ____

Supplier #'s: ____

Medicare Supplier Number (PTAN) *NPI Number*

LINKIA
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Remit to Address

☐ Same location ☐ Different location

Address: ______________________________

Street Name and Number *Suite, Room, etc.*

____

City *State* *ZIP Code + 4*

EDI: ______________________________

Vendor Name *Contact Number* *Contact Name*

Services Provided

Which of the following services do you provide in your office? (Check all that apply)

Comprehensive O&P

☐ **Limb Prostheses** (PR01)

☐ **Orthoses: Custom Fabricated** (OR01)

☐ **Orthoses: Prefabricated** (OR02)

☐ **Orthoses: Off-the-Shelf** (OR03)

☐ **Diabetic Shoes/Inserts** (S02)

☐ **Diabetic Shoes/Inserts—Custom** (S03)

Other O&P Related Services

**Requires Certified Mastectomy Fitter*
***May require a DME license per state-level regulations.*

☐ **Breast Prostheses and/or Accessories** (PD01) *

☐ **WalkAide**** - Neuromuscular Electrical Stimulators (NMES) and/ or Supplies **(DM16)**

AAD or DME Accreditation and/or License Required

*See: **Palmetto GBA DMEPOS License Directory** for state level requirements*

☐ Canes and/or Crutches (M01)

☐ Commodes/Urinals/Bedpans (DM02)

☐ Continuous Passive Motion (CPM) Devices (DM03)

☐ Contracture Treatment Devices: Dynamic Splint (DM04)

☐ Heat & Cold Applications (DM08)

☐ Infrared Heating Pads Systems and/or supplies (DM11)

☐ Negative Pressure Wound Therapy Pumps and/ or Supplies (DM15)

☐ Penile Pumps (OR04)

☐ Pneumatic Compression Devices and/or Supplies (DM18)

☐ Seat Lift Mechanisms (M04)

☐ Surgical Dressings (S01)

☐ Traction Equipment (DM21)

☐ Transcutaneous Electrical Nerve Stimulators (TENS) and/or Supplies

Walkers (M05)

☐ Neurostimulators and/or Supplies (PD04)

☐ Osteogenesis Stimulators (OR03)

☐ Patient Lifts (M02)

☐ Wheelchair Seating/Cushions (M10)

☐ Wheelchairs—Standard Manual (M06)

☐ Wheelchairs—Standard Manual Related Accessories (M06)

☐ **Other (please specify):**

Certified Orthotist, Prosthetist, Pedorthist or Mastectomy Fitter

Clinician Name	Date of Birth	Specialty (CP/CO/CPO etc...)	Certification and License #	Expiration Date

Please email or fax this completed notification form with supporting applicable documentation to:

RCMBilling@Hanger.com or fax to 512-201-6060

Please allow 45 – 60 days to process your request. A W-9 form, Medicare Letter, and Office Accreditation is required for tax ID updates.

Note: Request may require an updated Linkia Provider Application and credentialing approval.

INTERNAL USE ONLY:

Updates made to applicable systems: ________________________________

Signature:____________________________

(Print) ______________________________

Date:_______________