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SPOT

Submitter ID Update Request Form

Please complete this form and return it to First Coast Service Options Inc. to update the information we have on file for your SPOT submitter ID. Please note, once these changes have been completed, you **MUST** update your Identity Management (IDM) system enrollment the following business day to avoid impacts to your Organization's First Coast SPOT access. A fax will be sent to confirm we have completed your request.

All fields marked with an * are required. Please type or print clearly.

General Information

R2-23

*State:	*Line of business:

Current Provider Information

*Current Tax ID or SPOT submitter ID:	*Current legal business name:	Correspondence fax number:
*Correspondence mailing address (Street, City, State/Province, ZIP code/Postal code):		

All SPOT Submitter IDs with the same Tax ID will be updated.

*Change information on file to (check only those that apply):

	Legal business name:		
	Contact person's name:		Contact person's telephone number:
	Street Address:		City:
	State/Province:		ZIP code/Postal code:
	Tax ID:		
	Approver first name:	Approver last name:	Approver email:
	Backup Approver first name:	Backup Approver last name:	Backup Approver email:

*The Authorized Official signing this form should be an AUTHORIZED OR DELEGATED OFFICIAL that was listed on the Medicare Enrollment Application (CMS-855).

*Required Signature

*Written Signature of Person Submitting Form (add after you print the form):	*Date (mm/dd/yyyy):
*Printed Name of Person Submitting Form:	*Printed Title of Person Submitting Form:

Complete form, print, sign, date, and email (recommended), mail, OR fax all pages to:

Email: MedicareEDI@fcso.com Fax: (904) 361-0470

Post: First Coast Medicare EDI, P.O. Box 3703, Mechanicsburg, PA 17055-1861

Allow 10 business days for processing. Please do not send duplicate forms.