AAAHC
ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

Change Notification Form

		Date Submitted:	3/24/2020
Organization Name:	Surgery Center	**AAAHC ID#:**	121212
Organization Type:	Medicare ASC	**Accreditation Expiration Date:**	5/22/2021
Address:	5250 Old Orchard Rd, Suite 100	**State:**	OH
Primary Contact:	Sally Sample	**Email:**	samples@surgerycenter.org
Effective date (for change):	3/27/2020-indefinately. Open intermittently during this time for emergency procedures.		

If the primary contact has changed, select admin change and enter details in top section.

Select Temporary Closure and document narrative above

STEP 1: Identify change(s) an ation. Select type(s) of change from each r below. Check all that apply. F er or submit (as email attachment) the info

Group 1: Simple changes

☑ **Admin Change** Name Position Email Phone Effective Date Designate this person as primary contact? ☑ YES ☐ NO If No, who should be the primary contact?	☐ **Name Change (Legal and/or DBA)** Submit: ► Copy of updated license/state notification ► Copy of license with submission ► CMS approval letter for Medicare Certified organizations	☐ **End of Accreditation/ Closure** Submit: ► Narrative (Please include date of closure.)	☑ **Temporary Closure/ Interruption of Services** Submit: ► Narrative (Please include begin and end date of service interruption.)

Select Yes if you have a CCN. No need to complete all fields if not applicable

STEP 2: Medicare Information (if CMS certified). Please forward any proof of acceptance or confirmation from CMS.

Date the Medicare enrollment Form CMS-855B was filled with the fiscal intermediary for review and verification:			
Is the organization planning on maintaining the current CCN number?			☑ YES ☐ NO
Previous CCN Number		New CCN Number	
Will the new owner accept assignment of the current/prior owner's Medicare provider agreement?			☐ YES ☐ NO

STEP 3: Attestation and Signature

By signing below, I certify that the information in this application is accurate, complete, and current as of this date. I acknowledge that the AAAHC policies must be continually adhered to. Any material change in the relationship between the applicant organization and the new service site(s) being requested to be added must be reported to the AAAHC.

Sally Sample	Administrator	S. Sample	3/23/2020
Name	**Title**	**Sign**	**Date**

STEP 4: Send to AAAHC. Save this completed form to your computer and email it along with all required attachments to:
For primary care: notifyprimarycare@aaahc.org
For Corporate Quality Alliance (CQA) organizations: notifyCQA@aaahc.org
For surgical organizations EAST (of the Mississippi River): notifyEast@aaahc.org
For surgical organizations WEST (of the Mississippi River): notifyWest@aaahc.org

Sign and email to notifyEast@aaahc.org