



## Information Change Form

**Instructions:** Write in the fields of the form that apply to the information you need to change in PPL's system. Not all fields need to be filled in. Send the finished form to PPL by fax at 833-920-0703, by email at PPLODMMyCare@pplfirst.com, or by mail to our address:

Public Partnerships LLC, 17 Plaza Drive, Suite 300 Latham, NY 12110.

I am (check one): ☐ A Provider ☐ A Representative

My PPL ID is: \_\_\_\_\_

### Name Change Section

My prior name was (first, middle, and last): \_\_\_\_\_

My name has changed to (first, middle, and last): \_\_\_\_\_

Did you attach the identity documents showing the above name change? ☐ Yes ☐ No

**Note:** PPL cannot update name records without a copy of the new social security card and picture ID.

### Contact Information Change Section

☐ Remove my prior email address: \_\_\_\_\_

☐ Add my email address: \_\_\_\_\_

☐ Remove my prior cell phone number: \_\_\_\_\_

☐ Add my cell phone number: \_\_\_\_\_

☐ Remove my prior home phone number: \_\_\_\_\_

☐ Add my home phone number: \_\_\_\_\_

☐ Remove my prior physical address: \_\_\_\_\_

☐ Add my new physical address: \_\_\_\_\_

☐ Remove my prior mailing address: \_\_\_\_\_

☐ Add my new mailing address: \_\_\_\_\_

### Agree and sign:

By signing below, I confirm that:

- The above changes I have requested are complete and correct.
- I am asking PPL to change the information in PPL's electronic system to match what I have entered above.

**Your Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Your Name (please print):** \_\_\_\_\_