

CHANGE INFORMATION FORM: PARTICIPANT or EMPLOYER



Please complete this form and return to Acumen by one of the following methods:

Mail: 5416 E. Baseline Rd., Suite 200, Mesa, AZ 85206

Fax: (855) 264-3287

Email: tx-medicaid@acumen2.net

Change PARTICIPANT Information

Complete this section when there is a change in participant information. The participant is the individual receiving services. If the participant is also the employer, please complete this section **only**. For a name change, provide the previous name, new name, and attach a legal document supporting the name change.

Change In (select all that apply): Name ☐ Address ☐ Phone Number ☐ E-mail Address ☐	
Current/Previous Name:	New Name (if changed):
Street Address:	
City/State/Zip:	
Phone Number:	
E-mail Address:	
Client ID Number:	
Signature (Employer or Authorized Rep):	
Date:	

Change EMPLOYER Information

Complete this section when there is a change in employer information. The employer is the individual who hires, trains, and manages staff. If the participant is also the employer, please complete the participant section only. For a name change, provide the previous name, new name, and attach a legal document supporting the name change.

Change In (select all that apply): Name ☐ Address ☐ Phone Number ☐ E-mail Address ☐	
Current/Previous Name:	New Name (if changed):
Street Address (if changed):	
City/State/Zip (if changed):	
Phone Number (if changed):	
E-mail Address:	
Client ID Number:	
Signature (Employer or Authorized Rep):	
Date:	

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