New Jersey Department of
Human Services
Division of Aging Services

Salesforce Government Cloud

PROVIDER PROFILE CHANGE REQUEST

*Required

*Date: _____

A. CHANGE REQUEST TYPE

*Salesforce Portal *(Check One)*:

☐ EARC Portal *(Hospital)* ☐ NF Portal *(NF/SCNF)*

*Provider Profile Changes Requested *(Check all that apply)*

☐ Name Change ☐ Medicaid Provider Number

☐ Address Change ☐ Provider Type ☐ Provider Email Change

B. CURRENT PROVIDER PROFILE INFORMATION *(Prior to Change)*

*Name of Provider Organization: _____

(Check One) ☐ Hospital ☐ NF ☐ SCNF *(specify type)* _____

*Medicaid Provider Number: _____

*Street Address: _____

*City, State, Zip and County: _____

*Telephone: _____

*Organizational Email *(not portal user email, required for NF/SCNF)*:

_____

C. UPDATED PROVIDER PROFILE DETAIL

(Complete only those items where changes to the provider profile are requested)

Name of Provider Organization: _____

(Check One) ☐ Hospital ☐ NF ☐ SCNF *(specify type)* _____

Medicaid Provider Number: _____

Street Address: _____

City, State, Zip and County: _____

Telephone: _____

New Organizational Email: _____

D. REQUESTOR CERTIFICATION

As the Information Security Representative (ISR) on file with the Division of Aging Services (DoAS) for the above named provider, I certify the changes requested are accurate. These changes have also been made known to the NJ Department of Health, and other State entities as applicable.

*Name of ISR: _____

*Title of Requestor: _____

*Signature of Requestor: _____

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E. EMAIL INSTRUCTIONS

Submit a fully completed SF-3, PROVIDER PROFILE CHANGE REQUEST form to DoAS via the appropriate email listed below; handwritten and/or faxed submissions will not be accepted.

- EARC Portal – Email: EARCRegistration@dhs.nj.gov
- NF Portal – Email: Doas-NFPortal.Registration@dhs.nj.gov

NOTE: *Forms with any required information (*) missing, shall be returned for completion. Please submit any comments or questions to the appropriate email above.*

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