New Jersey Department of
Human Services
Division of Aging Services

Salesforce Government Cloud

PROVIDER PROFILE CHANGE REQUEST

*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 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 Facility Email: _____

D. REQUESTOR CERTIFICATION

As the Information Security Representative on file with the Division of Aging Services for the above named facility, I certify the changes requested are accurate. These changes have also been made known to the Department of Health, or other state entities as applicable.

Name of ISR: _____

Signature of ISR: _____

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E. EMAIL INSTRUCTIONS

Forward this fully completed SF-3, PROVIDER PROFILE CHANGE REQUEST form via email attachment to DoAS as applicable. 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