MEDICAL PROVIDER CHANGE FORM

Community HealthChoices | AmeriHealth Caritas Pennsylvania

CURRENT PRACTICE INFORMATION

Group Practice Name/Individual Name: _____
(Please Circle One ↑)

Group Practice ID/Individual ID: AmeriHealth Caritas PA CHC ID: _____ NPI #_____ PPID# _____
(Please Circle One ↑)

_____ _____ _____ _____
Contact person name (please print clearly) Phone Fax Email address

_____ _____ _____
Authorizing signature (physician/office manager) Today's date Effective date of change
Change will not be completed without signature

PROVIDER CHANGE INFORMATION

Provide Complete Information – This request will be processed for AmeriHealth Caritas PA CHC. If any of these changes result in a change on your W-9, you must submit a copy of your W-9 with this change form. Please note: Practitioners must complete plan credentialing before they will be added to your practice as a participating provider. Refer to the AmeriHealth Caritas PA CHC website for credentialing requirements: **http://www.amerihealthcaritaschc.com/provider/credentialing/index.aspx**.

Type of change: (Please check all that apply)

- ☐ Adding a practice
- ☐ Joining a practice
- ☐ Phone change
- ☐ Adding an office location
- ☐ Changing an office location
- ☐ Other (attach documentation)
- ☐ Fax change
- ☐ Name change only

PREVIOUS OFFICE INFORMATION

AmeriHealth Caritas PA CHC Group Provider ID NPI

Name

Street address

City State ZIP

NEW OFFICE INFORMATION

AmeriHealth Caritas PA CHC Provider ID NPI

Name

Street address

City State ZIP

ADD PRACTITIONERS (New practitioners must complete AmeriHealth Caritas PA CHC Credentialing before they are added as a participating provider.)

1. _____ _____
Last First M.I. Degree NPI PPID

2. _____ _____
Last First M.I. Degree NPI PPID

TERMINATE PRACTITIONERS (Please give AmeriHealth Caritas PA CHC 60 days advance notice when a Practitioner is leaving the group.)

1. _____ _____
Last First M.I. Degree NPI PPID

2. _____ _____
Last First M.I. Degree NPI PPID

BILLING LOCATION CHANGE ☐

Street address 1 Telephone Fax Email address

Street address 2 Federal Tax ID (change in Federal ID requires new W-9)

Street address

City State ZIP

CHANGE OF OWNERSHIP ☐

Legal business name of new owner and federal tax ID (requires new W-9) Effective date of ownership

Please mail or fax this change form and supporting documents to:
AmeriHealth Caritas PA CHC, Provider Contracting Department, 8040 Carlson Road, Suite 500, Harrisburg, PA 17112 Fax 717-651-1673