

Long-Term Services and Supports (LTSS) Provider Change Form



CURRENT PRACTICE INFORMATION

Practice name/individual name: _____

(Please circle one ↑)

Practice ID/individual ID: AmeriHealth Caritas PA CHC ID: _____ PPID# _____

(Please circle one ↑)

Contact person name (please print clearly)	Phone	Fax	Email address
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Authorizing signature (provider/office manager) Change will not be completed without signature.	Today's date	Effective date of change
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PROVIDER CHANGE INFORMATION

Provide complete information. This request will be processed for AmeriHealth Caritas Pennsylvania (PA) Community HealthChoices (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.

Type of change (please check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Adding an office location | <input type="checkbox"/> Fax change | <input type="checkbox"/> Phone number change |
| <input type="checkbox"/> Changing an office location | <input type="checkbox"/> Name change only | <input type="checkbox"/> Other (attach documentation) |

PREVIOUS OFFICE INFORMATION

AmeriHealth Caritas PA CHC Provider ID

Name

Street address

City State ZIP

Service counties

NEW OFFICE INFORMATION

AmeriHealth Caritas PA CHC Provider ID

Name

Street address

City State ZIP

Service counties

BILLING LOCATION CHANGE

Street address 1	Phone	Fax	Email address
Street address 2	Federal tax ID		
Street address 3	(Note: A change in federal ID requires a new W-9.)		
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 fax or mail this change form and supporting documents to AmeriHealth Caritas PA CHC, Provider Contracting Department, 8040 Carlson Road, Suite 500, Harrisburg, PA 17112. Fax 1-717-651-1673.