Medical Provider Change Form

AmeriHealth Caritas Pennsylvania

AmeriHealth Caritas Pennsylvania

Current practice information			
☐ Group practice name: ☐ Individual name:			
☐ Group practice ID: ☐ Individual ID:	AmeriHealth Caritas Pennsylvania ID:	NPI:	PPID:
Contact person name (please print clearly):			Phone:
Email:			Fax:
Authorizing signature (physician/office manager) (Change will not be completed without a signature.)		Today's date:	Effective date of change:

Provider change information			
Please provide complete information. This request will be processed for AmeriHealth Caritas Pennsylvania. 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 our credentialing process before they will be added to your practice as a participating provider. Refer to our website for credentialing requirements: **www.amerihealthcaritaspa.com**.			
Type of change: Please check all that apply.	☐ Adding a practice ☐ Joining a practice ☐ Phone number change	☐ Adding an office location ☐ Changing an office location ☐ Other (attach documentation)	☐ Fax number change ☐ Name change only

Previous office information			New office information		
AmeriHealth Caritas Pennsylvania provider ID:		NPI:	AmeriHealth Caritas Pennsylvania provider ID:		NPI:
Name:			Name:		
Street address:			Street address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:	Fax:	Office hours:	Phone:	Fax:	Office hours:
☐ Close this location					

Add practitioners (New practitioners must complete our Credentialing process before they are added as a participating provider.)				
1. (Last name, first name, middle initial)	Degree:	NPI:	PPID:	
PPID location extension:	Street address:			
City:			State:	Zip:
PPID location extension:	Street address:			
City:			State:	Zip:
2. (Last name, first name, middle initial)	Degree:	NPI:	PPID:	
PPID location extension:	Street address:			
City:			State:	Zip:
PPID location extension:	Street address:			
City:			State:	Zip:
3. (Last name, first name, middle initial)	Degree:	NPI:	PPID:	
PPID location extension:	Street address:			
City:			State:	Zip:
PPID location extension:	Street address:			
City:			State:	Zip:

Terminate practitioners (Please give us 60 days' advance notice when a practitioner is leaving the group.)				
1. (Last name, first name, middle initial)	Degree:	NPI:	PPID:	
PPID location extension:	Street address:			
City:			State:	Zip:
PPID location extension:	Street address:			
City:			State:	Zip:
2. (Last name, first name, middle initial)	Degree:	NPI:	PPID:	
PPID location extension:	Street address:			
City:			State:	Zip:
PPID location extension:	Street address:			
City:			State:	Zip:
3. (Last name, first name, middle initial)	Degree:	NPI:	PPID:	
PPID location extension:	Street address:			
City:			State:	Zip:
PPID location extension:	Street address:			
City:			State:	Zip:
For additional changes/locations, please attach a separate sheet.				

Billing location change				
Street address 1:			Phone:	Fax:
Street address 2:			Email:	
City:	State:	Zip:	Federal Tax ID (change in federal ID requires new W-9):	

Change of ownership
Legal business name of new owner:
Federal Tax ID (requires new W-9):
Effective date of ownership:

Notes/comments

Please mail or fax this change form and supporting documents to:

AmeriHealth Caritas Pennsylvania
Provider Network Management
8040 Carlson Road, Suite 500
Harrisburg, PA 17112

Fax: 1-717-651-1673