PROVIDER CHANGE FORM

AmeriHealth Caritas
District of Columbia

CURRENT PRACTICE INFORMATION

Group practice name/individual name: _____
(Please circle one ↑)

Group practice ID/individual ID: AmeriHealth Caritas DC 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 District of Columbia (DC). 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:** Providers must complete AmeriHealth Caritas DC credentialing before they will be added to your practice as participating providers. Refer to the AmeriHealth Caritas DC website for credentialing requirements: **www.amerihealthcaritasdc.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 change
- ☐ Name change only
- ☐ New or changing federal tax ID

If the effective date of the change is different than above, please note the date next to change.

PREVIOUS OFFICE INFORMATION

AmeriHealth Caritas DC group provider ID _____ NPI _____

Name _____

Street address _____

City _____ State _____ ZIP _____

NEW OFFICE INFORMATION

AmeriHealth Caritas DC group provider ID _____ NPI _____

Name _____

Street address _____

City _____ State _____ ZIP _____

ADD PROVIDERS (New providers must complete AmeriHealth Caritas DC credentialing before they are added as participating providers.) Forms are available at **www.amerihealthcaritasdc.com/provider**.

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

TERMINATE PROVIDERS (Please give AmeriHealth Caritas DC 60 days of advance notice when a provider 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 _____

Street address 2 _____

Street address 3 _____

City _____ State _____ ZIP _____

Phone _____ Fax _____ Email address _____

Federal tax ID _____

(Note: A change in federal ID requires a new W-9 and a copy of the SS4 approval letter from the IRS.)

CHANGE OF OWNERSHIP ☐

Legal business name of new owner and federal tax ID (requires new W-9) _____ Effective date of ownership _____
Note: Terms of acquisition or purchase must be attached for processing.

Please mail or fax this change form and supporting documents to:
Amerihealth Caritas District of Columbia, Attn: Provider Network Management Department
1120 Vermont Avenue NW, 2nd Floor, Washington, DC 20005 / Fax 202-408-1277.