

Provider Change Form

Current practice information		
Group practice or individual name:		
Please check one: <input type="checkbox"/> Group practice <input type="checkbox"/> Individual		
Please check one: <input type="checkbox"/> Group practice ID number <input type="checkbox"/> Individual ID number		
AmeriHealth Caritas DC ID number:	NPI number:	PPID number:
Contact person name:		
Phone number:	Fax number:	
Email:		
Authorizing signature (provider or office manager):	Today's date:	Effective date of change:

Change will not be completed without signature.

Provider change information
<p>Provide complete information. This request will be processed for AmeriHealth Caritas District of Columbia (DC). If any of these changes result in a change to your W-9, you must submit a copy of your W-9 with this change form.</p> <p>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 at www.amerihealthcaritasdc.com.</p>
<p>Type of change (Please check all that apply.):</p> <p> <input type="checkbox"/> Adding a practice <input type="checkbox"/> Adding an office location <input type="checkbox"/> Name change <input type="checkbox"/> Joining a practice <input type="checkbox"/> Changing an office location <input type="checkbox"/> New or changing federal tax ID number <input type="checkbox"/> Phone number change <input type="checkbox"/> Fax number change <input type="checkbox"/> Other (attach documentation) </p> <p>If the effective date of the change is different than above, please note the date next to change.</p>

Previous office information		
AmeriHealth Caritas DC group provider ID number:	NPI number:	
Name:		
Street:		
City:	State:	ZIP:
Phone number:	Fax number:	

Provider Change Information (continued)



New office information		
AmeriHealth Caritas DC group provider ID number:		NPI number:
Name:		
Street:		
City:	State:	ZIP:
Phone number:	Fax number:	

Add providers		
New providers must complete AmeriHealth Caritas DC credentialing before they are added as participating providers. Forms are available at www.amerihhealthcaritasdc.com/provider .		
Last name:	First name:	M.I.
Degree:	NPI number:	PPID number:

Last name:	First name:	M.I.
Degree:	NPI number:	PPID number:

Terminate providers		
Please give AmeriHealth Caritas DC 60 days of advance notice when a provider is leaving the group.		
Last name:	First name:	M.I.
Degree:	NPI number:	PPID number:
Last name:	First name:	M.I.
Degree:	NPI number:	PPID number:

Billing location change		
Address 1:		
Address 2:		
Address 3:		
Phone number:	Fax number:	
Email address:	Federal tax ID number: (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:		Effective date of ownership:

Legal business name of new owner and federal tax ID number (requires new W-9)
 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**.