AmeriHealth

Provider Change Form

Reference:
Date Received: _____

Current Practice Information

This change affects: ❑ Group Practice ❑ Individual Physician

(Group Practice) or (Individual Physician) Name: _____

NPI: ☐☐☐☐☐☐☐☐☐☐ NPI Effective Date: ____ / ____ /____

(Group Practice) or (Individual Physician) Provider Number:

HMO ID #: ☐☐☐☐☐☐☐☐☐☐

PPO ID #: ☐☐☐☐☐☐☐☐☐☐

PHONE #: ☐☐☐☐☐☐☐☐☐☐

Contact Person: _____

(Change will not be completed without signature)

Authorizing Signature: _____

(Physician/Office Manager signature required)

Effective Date of Change: ____ / ____ /____

Today's Date: ____ / ____ /____

Provider Change Information

PROVIDE COMPLETE INFORMATION – Your request will be processed for the HMO & PPO Line of Business. **Changes will be effective within 30 days**. If any of these changes result in a change on your W-9, you must submit a copy of your W-9 Form with this change form.

Type of Change: *(Check all that apply)*

❑ Adding a practice ❑ Joining a practice ❑ Adding an Office Location ❑ Changing an Office Location ❑ Telephone ❑ Fax ❑ Name Change Only ❑ Tax ID Change

PREVIOUS OFFICE INFORMATION

_____
Name

_____
Street Address

_____
City State Zip

(_____) _____ (_____) _____
Telephone Fax

HMO Group Practice Provider: _____

PBS Group Practice Provider: _____

NEW OFFICE INFORMATION

_____
Name

_____
Street Address

_____
City State Zip

(_____) _____ (_____) _____
Telephone Fax

HMO Group Practice Provider: _____

PBS Group Practice Provider: _____

Physician Members – Please check each as an Add or a Delete to your practice.

1. _____ _____
Last First Middle Degree

2. _____ _____
Last First Middle Degree

3. _____ _____
Last First Middle Degree

4. _____ _____
Last First Middle Degree

ADD DELETE
Individual Provider ID#: ☐☐☐☐☐☐☐☐☐☐ ☐ ☐
NPI: ☐☐☐☐☐☐☐☐☐☐ NPI Eff. Date: ___ / ___ / ___
Taxonomy Code: _____

ADD DELETE
Individual Provider ID#: ☐☐☐☐☐☐☐☐☐☐ ☐ ☐
NPI: ☐☐☐☐☐☐☐☐☐☐ NPI Eff. Date: ___ / ___ / ___
Taxonomy Code: _____

ADD DELETE
Individual Provider ID#: ☐☐☐☐☐☐☐☐☐☐ ☐ ☐
NPI: ☐☐☐☐☐☐☐☐☐☐ NPI Eff. Date: ___ / ___ / ___
Taxonomy Code: _____

ADD DELETE
Individual Provider ID#: ☐☐☐☐☐☐☐☐☐☐ ☐ ☐
NPI: ☐☐☐☐☐☐☐☐☐☐ NPI Eff. Date: ___ / ___ / ___
Taxonomy Code: _____

❑ BILLING LOCATION

_____
Street Address 1

_____
Street Address 2

_____
City State Zip

(_____) _____
Telephone

(_____) _____
Fax

_____
Federal Tax ID #

❑ CHANGE OF OWNERSHIP (requires NPI certification form)

Legal Business Name of New Owner: _____ _____
Last First Middle Degree

Projected Effective Date of Change of Ownership: _____ / _____ / _____

Tax ID Number of Potential New Owner (*Requires a new W-9 Form*): _____

Please Provide a brief explanation of Change/Request: _____