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 provide _____

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: _____

Please mail or fax this change form and supporting document to: Network Administration; AmeriHealth; P.O. Box 41431; Philadelphia, PA19101-1431; Fax 215-988-6080