Provider Add/Change Form Please print clearly.

AmeriHealth Caritas Next

A product of AmeriHealth Caritas VIP Next, Inc.

CURRENT PRACTICE INFORMATION

☐ Group practice ☐ Individual _____ Name

☐ Group practice ID ☐ Individual ID _____ AmeriHealth Caritas Next ID _____ NPI number

_____ Contact person name _____ Phone _____ Fax _____ Email

_____ Authorizing signature (physician/office manager). Change will not be completed without signature. _____ Today's date _____ Effective date of change

PROVIDER CHANGE INFORMATION

Provide complete information. This request will be processed for AmeriHealth Caritas Next. If any of these changes result in a change on your W-9, you must submit a copy of your W-9 with this form. **Please note:** Providers must complete AmeriHealth Caritas Next credentialing before they will be added to your practice as participating providers. Refer to the AmeriHealth Caritas Next website for credentialing requirements: **www.amerihealthcaritasnext.com**.

Type of change (check all that apply):

☐ Adding a practice
☐ Adding an office location
☐ Fax change
☐ Joining a practice
☐ Changing an office location
☐ Name change only
☐ Phone number change
☐ Open/closed panel
☐ New or changing federal tax ID
☐ Other (attach documentation)

PROVIDER GROUP INFORMATION

CURRENT OFFICE INFORMATION

_____ AmeriHealth Caritas Next group provider ID NPI

_____ Name

_____ Street address

_____ City State ZIP

NEW OFFICE INFORMATION, IF APPLICABLE

_____ AmeriHealth Caritas Next group provider ID NPI

_____ Name

_____ Street address

_____ City State ZIP

INDIVIDUAL PROVIDER INFORMATION

ADD PROVIDERS (New providers must complete AmeriHealth Caritas Next credentialing before they will be added as participating providers. Forms are available at **www.amerihealthcaritasnext.com**)

1. _____ Last First M.I. Degree _____ NPI MAID CAQH number
2. _____ Last First M.I. Degree _____ NPI MAID CAQH number

TERMINATE PROVIDERS (Please give AmeriHealth Caritas Next 60 days of advance notice when a provider is leaving the group.)

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

BILLING LOCATION UPDATE

_____ Street address 1 _____ Phone Fax Email

_____ Street address 2 _____ Federal tax ID

_____ Street address 3 **(Note: A change in federal ID requires a new W-9 and a copy of the SS4 approval letter from the IRS.)**

_____ City State ZIP

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 email this form and supporting documents to acdevipnext@amerihealthcaritas.com.