

Provider Add/Change Form Please print clearly.



AmeriHealth Caritas

Next

A product of AmeriHealth Caritas North Carolina, 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):

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Adding a practice | <input type="checkbox"/> Joining a practice | <input type="checkbox"/> Phone number change | <input type="checkbox"/> Other (attach documentation) |
| <input type="checkbox"/> Adding an office location | <input type="checkbox"/> Changing an office location | <input type="checkbox"/> Open/closed panel | |
| <input type="checkbox"/> Fax change | <input type="checkbox"/> Name change only | <input type="checkbox"/> New or changing federal tax ID | |

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 _____

City _____ State _____ ZIP _____

(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.