

Provider Change Form

Current practice information			
Check one: <input type="checkbox"/> Group practice <input type="checkbox"/> Individual <input type="checkbox"/> Facility		Name:	
Check one: <input type="checkbox"/> Group practice ID <input type="checkbox"/> Individual ID	AmeriHealth Caritas Louisiana ID:	NPI number:	TIN number:
Contact person name:			
Phone:	Fax:	Email:	
Authorizing signature:		Today's date:	Effective date of change:

Provider change information
<p>Provide complete information: This request will be processed for AmeriHealth Caritas Louisiana. If any of these changes result in a change on your W-9, you must submit a copy of your W-9 with this change form.</p> <p>Please note: Practitioners must complete AmeriHealth Caritas Louisiana credentialing before they will be added to your practice as a participating provider. Refer to the AmeriHealth Caritas Louisiana website for credentialing requirements at www.amerihealthcaritasla.com.</p>
<p>Type of change: (please check all that apply)</p> <p> <input type="checkbox"/> Phone <input type="checkbox"/> Name <input type="checkbox"/> Office location <input type="checkbox"/> Remit <input type="checkbox"/> Open panel: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Fax <input type="checkbox"/> Adding an office location <input type="checkbox"/> Taxonomy <input type="checkbox"/> Other </p>

Previous office information		
AmeriHealth Caritas Louisiana provider ID:	Tax ID number:	NPI number:
Name:		
Street address:		
City:	State:	ZIP code:
Phone:	Fax:	Email:

Provider Change Form



New office information					
AmeriHealth Caritas Louisiana provider ID:			Tax ID number:		NPI number:
Name:					
Street address:					
City:			State:		ZIP code:
Phone:		Fax:		Email:	

Update/change taxonomy (If more space is required, please use additional form.)					
Last:	First:	M.I.:	Degree:	Taxonomy:	Taxonomy:
Last:	First:	M.I.:	Degree:	Taxonomy:	Taxonomy:

Terminate practitioners (Please give AmeriHealth Caritas Louisiana 60 days' advance notice when a practitioner is leaving the group.)					
Last:	First:	M.I.:	NPI number:	PPID:	
Last:	First:	M.I.:	NPI number:	PPID:	

Billing location change					
Street address 1 or P.O. Box:					
Street address 2 or P.O. Box:					
City:			State:		ZIP code:
Phone:		Fax:		Email:	
Federal tax ID (change in federal ID requires new W-9):					
Change of ownership (legal business name of new owner and federal tax ID [requires new W-9]):					Effective date of ownership:

Please mail or fax this change form and supporting documents to:

AmeriHealth Caritas Louisiana
 Provider Network Management
 P.O. Box 83580
 Baton Rouge, LA 70084
 Fax: 1-888-972-4290



www.amerihealthcaritasla.com