PROVIDER CHANGE FORM

CURRENT PRACTICE INFORMATION

Group practice name/individual name: ______________________________
(Please circle one ↑)

Group practice ID/individual ID: AmeriHealth Caritas Iowa ID:__________ NPI #__________ MAID#__________
(Please circle one ↑)

Contact person name (please print clearly) | Phone | Fax | Email address

Authorizing signature (physician/office manager) | Today's date | Effective date of change

Change will not be completed without signature.

PROVIDER CHANGE INFORMATION

Provide complete information. This request will be processed for AmeriHealth Caritas Iowa. 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. **Please note:** Providers must complete AmeriHealth Caritas Iowa credentialing before they will be added to your practice as participating providers. Refer to the AmeriHealth Caritas Iowa website for credentialing requirements: **www.amerihealthcaritasia.com**.

Type of change: (Please 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)

PREVIOUS OFFICE INFORMATION

AmeriHealth Caritas Iowa group provider ID | NPI

Name

Street address

City | State | ZIP

NEW OFFICE INFORMATION

AmeriHealth Caritas Iowa group provider ID | NPI

Name

Street address

City | State | ZIP

ADD PROVIDERS (New providers must complete AmeriHealth Caritas Iowa credentialing before they are added as participating providers. Forms are available at **www.amerihealthcaritasia.com/provider**.)

1. Last | First | M.I. | Degree | NPI | MAID
2. Last | First | M.I. | Degree | NPI | MAID

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

1. Last | First | M.I. | Degree | NPI | MAID
2. Last | First | M.I. | Degree | NPI | MAID

BILLING LOCATION CHANGE ☐

Street address 1

Street address 2

Street address 3

City | State | ZIP

Phone | Fax | Email address

Federal tax ID

(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.

Please fax or mail this change form and supporting documents to 1-844-412-7893 or iowaprovidernetwork@amerihealthcaritas.com or AmeriHealth Caritas Iowa, Attn: Provider Network Management, Two Ruan Center, 601 Locust Street, Suite 900, Des Moines, IA 50309.

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