AmeriHealth

Internal use only
Reference: _____
Date received: _____

Provider Change Form

(*Denotes a required field/section)

1. Current practice information*			
Group practice name:			
Group practice NPI number:			
Street address 1:		Street address 2:	
City:	State:	ZIP:	Fax:
Contact person: Phone #:		Authorizing signature: *(Physician/office manager signature required)* Phone #:	
Effective date of change:		Today's date:	

2. Provider change information*

Provide complete information – Your request will be processed for all of your active lines of business. **Changes will be effective within 30 business days.** If any of these changes will 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):

- ☐ Update current office information (Field 3):
  - ☐ Practice name
  - ☐ Phone number
  - ☐ Address
  - ☐ Fax number
- ☐ Add/Delete an office location (Field 4)
- ☐ Add/Delete a physician to/from existing group (Field 5)
- ☐ New mailing address (Field 6)
- ☐ New payment information (Field 7)

3. Update current office information* ☐ Keep current ☐ Delete ☐ Update (update relevant information below)

Group practice name:		
Street address 1:		Street address 2:
City:	State:	ZIP:
Telephone:		Fax:

4. Office locations – Please check each as an Add or a Delete to your practice. (see page 2, Field 9 to add additional office locations)

1. Group practice name:			Group practice NPI #: ☐ Add ☐ Delete
Street address 1:			Effective date:
Street address 2:			
City:	State:	ZIP:	
Telephone:	Fax:		

5. Physicians – Please check each as an Add or a Delete to your practice. (see page 2, Field 10 to add additional physicians)

1. Name (last, first, middle):	Individual provider NPI #: ☐ Add ☐ Delete
Specialty:	Effective date:

6. New mailing address (if different from your current practice information address in Field 1)

Street Address 1:			Telephone:	Fax:
Street Address 2:			Federal tax ID #:	
City:	State:	Zip:		

7. New payment information (if different from your current practice information address in Field 1)

Street Address 1:			Telephone:	Fax:
Street Address 2:			Federal tax ID #:	
City:	State:	ZIP:		

8. Current practice information* (Required if adding/deleting offices and/or physicians from page 1. Same as Field 1 on page 1.)			
Group practice name:			
Group practice NPI number:			
9. Additional office locations – Please check each as an Add or a Delete to your practice.†			
2. Group practice name:			Group practice NPI #: ☐ Add ☐ Delete
Street address 1:			Effective date:
Street address 2:			
City:	State:	ZIP:	
Telephone:	Fax:		
3. Group practice name:			Group practice NPI #: ☐ Add ☐ Delete
Street address 1:			Effective date:
Street address 2:			
City:	State:	ZIP:	
Telephone:	Fax:		

10. Additional physicians – Please check each as an Add or a Delete to your practice.†	
2. Name (last, first, middle): Specialty:	Individual provider NPI#: ☐ Add ☐ Delete Effective date:
3. Name (last, first, middle): Specialty:	Individual provider NPI#: ☐ Add ☐ Delete Effective date:
4. Name (last, first, middle): Specialty:	Individual provider NPI#: ☐ Add ☐ Delete Effective date:
5. Name (last, first, middle): Specialty:	Individual provider NPI#: ☐ Add ☐ Delete Effective date:

**Denotes a required field/section.*

†*If there are additional office locations or physicians, feel free to copy the form to accommodate.*

AmeriHealth HMO, Inc. (AmeriHealth) will not be responsible for changes not processed due to lack of proper notice from the Provider. Refer to "Resignation/termination from the AmeriHealth network" in the Administrative Procedures section of the *Provider Manual for Participating Professional Providers* for more information regarding the lead time requirements.

Please fax (preferred) or mail this change form and supporting documentation to:

Fax: (Preferred method of submission)
215-238-2275

Mail:
AmeriHealth
Attn: Network Administration
P.O. Box 41431
Philadelphia, PA 19101-1431