PROVIDER CHANGE FORM

AmeriHealth Caritas VIP Care Plus

CURRENT PRACTICE INFORMATION
ALL FIELDS IN THIS SECTION ARE **REQUIRED**

Type of Provider: Ancillary ☐ Specialist ☐ Primary care practitioner ☐ Hospital ☐ Urgent care ☐

Type 1 NPI: ______________________ Type 2 NPI: _____________________ Tax Identification Number: _____________________

Provider name: ____________________________ Group name: _____________________________Today's Date: _______________

Contact person: ________________________ Phone: __________________________ Email:________________________________

Authorizing signature: _________________________________ Authorizing signature printed: _______________________________

PROVIDER CHANGE INFORMATION

PROVIDE COMPLETE INFORMATION – This request will be processed for AmeriHealth Caritas VIP Care Plus. Changes will be effective within 45 days. 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 use the check box to identify your change request. Please print or type.

☐ **Adding a practice** ☐ **Deleting a practice address** ☐ **Billing address change*** ☐ **Telephone/fax change** ☐ **Office hours**
☐ **Include in provider directory** ☐ **Exclude in provider directory** ☐ **Correct a practice address**

Street: ____City:_________________State: __________Zip:__________

Phone: (______)______________ Fax: (_____)______________________Office hours: ____

☐ **Tax Identification change*** New Tax Identification Number: _________________________________

☐ **Change of ownership *** ____ Effective date of ownership:________________
Legal business name of new owner

☐ **Name change only** Current name: _______________________________ New name: ________________________________

☐ **Panel changes**
Open panel
Close panel to all new members, but keep existing members
Close panel to all members
Close panel to all members (new and existing) and reassign to the following practitioner: _______________________
Last name, First name

☐ **Termination from AmeriHealth Caritas VIP Care Plus** Explanation/Reason for termination: _____________________________________

If a PCP, who will be assuming your patient panel: _____________________________________
Last name, First name

REQUIREMENTS & GUIDELINES

REQUIREMENTS:

To efficiently process the change request, please complete the required fields in the *CURRENT PRACTICE INFORMATION* section.
The following types of changes require the submission of the W-9 form (*tax form which certified an individual's tax identification number*)

1. Billing address change
2. Tax ID change
3. Group name change
4. Change of ownership

GUIDELINES:

1. If you are submitting a request to change a physician's name, please submit a copy of a marriage license, divorce decree, etc. as supporting documentation.
2. If your office has a Tax Identification Number change, please submit to AmeriHealth Caritas VIP Care Plus as soon as it is available to ensure timely and accurate processing. A delay in notification may interrupt claims processing.
3. Physicians must complete AmeriHealth Caritas VIP Care Plus credentialing before they will be added to your practice as a participating provider. You may access the enrollment forms at www.amerihealthcaritasvipcareplus.com/provider

PLEASE EMAIL, FAX OR MAIL THIS CHANGE FORM, ALONG WITH SUPPORTING DOCUMENTATION, TO:
AmeriHealth Caritas VIP Care Plus, Attn: Provider Data Management, 100 Galleria Officentre; Suite 210, Southfield MI 48034 Fax #: 1-855-306-9762
MichiganProviderNetwork@amerihealthcaritas.com

***INDICATES A W-9 FORM IS REQUIRED**

Effective: 10/1/2015