AmeriHealth Caritas
District of Columbia

Provider Change Form

Current practice information

Group practice or individual name:			
Please check one:	☐ Group practice	☐ Individual	
Please check one:	☐ Group practice ID number	☐ Individual ID number	
AmeriHealth Caritas DC ID number:		NPI number:	PPID number:
Contact person name:			
Phone number:		Fax number:	
Email:			
Authorizing signature (provider or 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 District of Columbia (DC). If any of these changes result in a change to your W-9, you must submit a copy of your W-9 with this change form.

Please note: Providers must complete AmeriHealth Caritas DC credentialing before they will be added to your practice as participating providers. Refer to the AmeriHealth Caritas DC website for credentialing requirements at **www.amerihealthcaritasdc.com**.

Type of change (Please check all that apply.):

☐ Adding a practice	☐ Adding an office location	☐ Name change
☐ Joining a practice	☐ Changing an office location	☐ New or changing federal tax ID number
☐ Phone number change	☐ Fax number change	☐ Other (attach documentation)

If the effective date of the change is different than above, please note the date next to change.

Previous office information

AmeriHealth Caritas DC group provider ID number:		NPI number:
Name:		
Street:		
City:	State:	ZIP:
Phone number:	Fax number:	

New office information

AmeriHealth Caritas DC group provider ID number:		NPI number:
Name:		
Street:		
City:	State:	ZIP:
Phone number:	Fax number:	

Add providers

New providers must complete AmeriHealth Caritas DC credentialing before they are added as participating providers.
Forms are available at **www.amerihealthcaritasdc.com/provider**.

Last name:	First name:	M.I.
Degree:	NPI number:	PPID number:

Last name:	First name:	M.I.
Degree:	NPI number:	PPID number:

Terminate providers

Please give AmeriHealth Caritas DC 60 days of advance notice when a provider is leaving the group.

Last name:	First name:	M.I.
Degree:	NPI number:	PPID number:

Last name:	First name:	M.I.
Degree:	NPI number:	PPID number:

Billing location change

Address 1:		
Address 2:		
Address 3:		
Phone number:	Fax number:	
Email address:	Federal tax ID number: (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:		Effective date of ownership:

Legal business name of new owner and federal tax ID number (requires new W-9)
Note: Terms of acquisition or purchase must be attached for processing.

Please mail or fax this change form and supporting documents to:
AmeriHealth Caritas District of Columbia, Attn: Provider Network Management Department
1250 Maryland Avenue SW, Suite 500, Washington, DC 20024 / Fax **202-408-1277**