







Medical Provider Change Form

AmeriHealth Caritas Pennsylvania AmeriHealth Caritas Pennsylvania (PA) Community HealthChoices (CHC) AmeriHealth Caritas VIP Care

Current practice in	nformation								
☐ Group practice									
☐ Individual name							1		
☐ Group practice☐ Individual ID:	ID:		riHealth C rsylvania	aritas	NPI:		PPI	D:	
individual iD:				aritas PA CHC					
			riHealth C	aritas VIP Care					
		ID:							
Contact person name (please print clearly):			Ph		Pho	one:			
Email:							Fax	:	
Authorizing signat					Today's date:		Effe	ctive d	ate of change:
(Change will not be con	npleted without a	signatur	e.)						
Provider change i	nformation								
Please provide com		on This	request wi	ill he processed f	or AmeriHealth C	aritas Pennsylv	vania Am	eriHealt	h Caritas PA CHC
and AmeriHealth Ca		011. 11113	request wi	iii be processed i	or / intermiteating et	intas i cimsyt	varria, mirr	- III ICUIL	ii cantas i // circ,
If any of these chan	ges result in a	change o	on your W-9	9, you must subn	nit a copy of your\	N-9 with this c	hange for	n. Plea s	se note:
Practitioners must of									
Refer to our website www.amerihealthc			irements: v	vww.amerihealtl	ncaritaspa.com, w	ww.amerihea	lthcaritas	chc.com	ı, and
Type of change:	untusvipeurere		lding a pra	ıctice	☐ Adding an o	office location	П	ax num	ber change
Please check all that ap	ply.	I	ining a pra		☐ Changing and				nange only
		I	none numb		☐ Other (attac				3 ,
Previous office inf	ormation				New office infor	mation			
AmeriHealth Caritas Pennsylvania, AmeriHealth Caritas PA CHC, and AmeriHealth Caritas VIP Care provider ID:				AmeriHealth Caritas Pennsylvania,			NPI:		
				AmeriHealth Caritas PA CHC, and AmeriHealth Caritas VIP Care provide			r ID•		
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Name:					Name:				
Street address:				Street address:					
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Phone:	Fax:		Office ho	urs:	Phone:	Fax:	1	Offic	e hours:
☐ Close this locat	ion		1						

Medical Provider Change Form



Add practitioners (New practitioners must comp	olete our credent	aling process before they are ad	lded as a narticin	ating provider)			
1.	Degree:	NPI:	PPID:	ating provider.)			
(Last name, first name, middle initial)	Degree.	W. I.	1116.				
PPID location extension:	Street address:						
City:			State:	ZIP:			
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(Last name, first name, middle initial)	Ctroot address.						
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City:			State:	ZIP:			
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3. (Last name, first name, middle initial)	Degree:	NPI:	PPID:				
PPID location extension:	Street address:						
City:			State:	ZIP:			
PPID location extension:							
City:			State:	ZIP:			
Terminate practitioners (Please give us 60 day	s' advance notic	e when a practitioner is leaving	the group)				
Terminate practitioners (Please give us 60 day							
Terminate practitioners (Please give us 60 day 1. (Last name, first name, middle initial)	s' advance notic Degree:	e when a practitioner is leaving	the group.) PPID:				
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Medical Provider Change Form



Billing location change	2				
Street address 1: Street address 2:			Phone:	Fax:	
			Email:		
City:	State:	ZIP:	Federal Tax ID (change in federal ID requires new W-		
Change of ownership					
Legal business name of	new owner:				
Federal Tax ID (requires	new W-9):				
Effective date of owners	ship:				
Notes/comments					
notes/ comments					

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

AmeriHealth Caritas Pennsylvania, AmeriHealth Caritas PA CHC, and AmeriHealth Caritas VIP Care Provider Network Management 8040 Carlson Road, Suite 500 Harrisburg, PA 17112

Fax: 1-717-651-1673