Change/Termination Form

Please print clearly.

AmeriHealth Caritas Louisiana

PRACTITIONER INFORMATION

☐ Group practice ☐ Individual	Name:			
☐ Group practice ID ☐ Individual ID	Race:	Ethnicity:		
AmeriHealth Caritas Louisiana ID:	NPI number:			
Provider type: ☐ Primary care provider (PCP) ☐ Specialist ☐ Behavioral health (BH) ☐ Allied health provider ☐ Hospital based				
Phone:	Fax:	Email:		
Street address:	City:	State:	ZIP:	
Authorizing signature (physician/office manager): Change will not be completed without signature.				
Today's date:	Effective date of change:			
Hospital admitting privileges:	Hospital affiliations:			
Cultural competency completion: ☐ Yes ☐ No	Spoken languages:			
ADA compliance: ☐ Yes ☐ No	Examination rooms — Compliant access (ADA3): ☐ Yes ☐ No			
Blind/visually impaired (ADA5): ☐ Yes ☐ No	Handicap-accessible medical equipment (ADA4): ☐ Yes ☐ No			
Cognitively disabled (ADA6): ☐ Yes ☐ No	Restrooms — Compliant access (ADA2): ☐ Yes ☐ No			
Deaf or hard of hearing (ADA7): ☐ Yes ☐ No	Service location — Compliant access (ADA1): ☐ Yes ☐ No			

CHANGE REQUEST TYPE

This request will be processed for AmeriHealth Caritas Louisiana. If any of these changes results in a change on your W-9, you must submit a copy of your W-9 with this form.

Type of change (check all that apply):

☐ Phone number change	☐ Billing location update	☐ Open/closed panel	☐ Other (attach documentation)
☐ Fax number change	☐ Practice location update	☐ Terminating a provider	☐ Remit address (W9 Required)

NAME CHANGE ONLY	Name change:

PROVIDER GROUP INFORMATION

CURRENT OFFICE INFORMATION

TIN:	NPI:	
Name:		
Street address:		
City:	State:	ZIP:
Phone:	Fax:	
Office hours: Mon: – Tues: – Wed: – Thurs: – Fri: – Sat: - Sun: –		

NEW OFFICE INFORMATION, IF APPLICABLE

Location name:		
TIN:	NPI:	
Name:		
Street address:		
City:	State:	ZIP:
Phone:	Fax:	
Office hours: Mon: – Tues: – Wed: – Thurs: – Fri: – Sat: – Sun: –		

PROVIDER TERMINATION

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

1. Last:	First:	M.I.:	Degree:	NPI:
2. Last:	First:	M.I.:	Degree:	NPI:

Termination reason (PCPs, please indicate below what participating provider [including physical location] you would like the member panel transferred to.)

BILLING DEMOGRAPHIC UPDATE

Street address 1:	City:	State:	ZIP:
Street address 2:	City:	State:	ZIP:
Street address 3:	City:	State:	ZIP:

Phone:	Fax:	Email:

Federal tax ID (change in federal ID requires new W-9):
Change of ownership (legal business name of new owner and federal tax ID [requires new W-9]):
Effective date of ownership:

Please email this form and supporting documents to **network@amerihealthcaritasla.com** or **fax to 1-225-300-9126**.

AmeriHealth Caritas Louisiana

www.amerihealthcaritasla.com