Provider Add/Change Form Please print clearly.

AmeriHealth Caritas Next
A product of AmeriHealth Caritas North Carolina, Inc.

CURRENT PRACTICE INFORMATION

☐ Group practice ☐ Individual _____
Name

☐ Group practice ID ☐ Individual ID _____ _____
AmeriHealth Caritas Next ID NPI number

_____ _____ _____ _____
Contact person name Phone Fax Email

_____ _____ _____
Authorizing signature (physician/office manager). Change will not be completed without signature. Today's date Effective date of change

PROVIDER CHANGE INFORMATION

Provide complete information. This request will be processed for AmeriHealth Caritas Next. If any of these changes result in a change on your W-9, you must submit a copy of your W-9 with this form. **Please note:** Providers must complete AmeriHealth Caritas Next credentialing before they will be added to your practice as participating providers. Refer to the AmeriHealth Caritas Next website for credentialing requirements: **www.amerihealthcaritasnext.com**.

Type of change (check all that apply):

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

PROVIDER GROUP INFORMATION

CURRENT OFFICE INFORMATION

_____
AmeriHealth Caritas Next group provider ID NPI

_____
Name

_____
Street address

_____
City State ZIP

NEW OFFICE INFORMATION, IF APPLICABLE

_____
AmeriHealth Caritas Next group provider ID NPI

_____
Name

_____
Street address

_____
City State ZIP

INDIVIDUAL PROVIDER INFORMATION

ADD PROVIDERS (New providers must complete AmeriHealth Caritas Next credentialing before they will be added as participating providers. Forms are available at **www.amerihealthcaritasnext.com**.)

1. _____ _____
Last First M.I. Degree NPI MAID CAQH number

2. _____ _____
Last First M.I. Degree NPI MAID CAQH number

TERMINATE PROVIDERS (Please give AmeriHealth Caritas Next 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

BILLING LOCATION UPDATE

_____ _____
Street address 1 Phone Fax Email

_____ _____
Street address 2 Federal tax ID

_____ **(Note: A change in federal ID requires a new W-9 and a copy of the SS4 approval letter from the IRS.)**
Street address 3

_____
City State ZIP

CHANGE OF OWNERSHIP

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

Please email this form and supporting documents to ProviderEnrollmentNCEX@amerihealthcaritas.com.