Change/Termination Form

Please print clearly.

AmeriHealth Caritas New Hampshire

PRACTITIONER INFORMATION

☐ Group practice ☐ Individual	Name:			
☐ Group practice ID ☐ Individual ID	AmeriHealth Caritas New Hampshire 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 AmeriHealthCaritas New Hampshire. 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	

NAME CHANGE ONLY	Name change:

PROVIDER GROUP INFORMATION

CURRENT OFFICE INFORMATION

TIN:	NPI:	
Name:		
Street address:		
City:	State:	ZIP:
Phone:	Fax:	

NEW OFFICE INFORMATION, IF APPLICABLE

Location name:		
TIN:	NPI:	
Name:		
Street address:		
City:	State:	ZIP:
Phone:	Fax:	

PROVIDER TERMINATION

TERMINATED PROVIDERS (Please give AmeriHealth Caritas New Hampshire 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:

Please fax or email this form and supporting documents to **1-833-301-2242** or **acnhprovidernetworkoperations@amerihealthcaritas.com**.

AmeriHealth Caritas™
New Hampshire

www.amerihealthcaritasnh.com