Long-Term Services and Supports (LTSS) Provider Change Form

Community HealthChoices | AmeriHealth Caritas Pennsylvania

CURRENT PROVIDER INFORMATION

Provider name: _____

AmeriHealth Caritas PA CHC ID: _____ PPID#: _____ TIN: _____

Contact person name (please print clearly) _____ Phone _____ Fax _____ Email address _____

Authorizing signature (provider/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 Pennsylvania (PA) Community HealthChoices (CHC).
If any of these changes result in a change on your W-9, you must submit a copy of your W-9 with this change form.

Type of change (please check all that apply):

- ☐ Adding an office location
- ☐ Changing an office location
- ☐ Fax change
- ☐ Name change only
- ☐ Phone number change
- ☐ Other (attach documentation)

PREVIOUS OFFICE INFORMATION ☐

Provider name

Street address

City State ZIP

Phone Fax

Email

NEW OFFICE INFORMATION

Provider name

Street address

City State ZIP

Phone Fax

Email

BILLING LOCATION CHANGE ☐

Street address 1

Street address 2

City State ZIP

Phone Fax Email address

Federal tax ID

(Note: A change in federal ID requires a 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 the completed form to chcproviders@amerihealthcaritas.com.

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