Provider Add/Change Form Please print clearly.

CURRENT PRACTICE INFORMATION

☐ Group practice ☐ Individual

Name

☐ Group practice ID ☐ Individual ID

First Choice 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 First Choice 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 First Choice Next credentialing before they will be added to your practice as participating providers. Refer to the First Choice Next website for credentialing requirements: **www.firstchoicenext.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

First Choice Next group provider ID NPI

Name

Street address

City State ZIP

NEW OFFICE INFORMATION, IF APPLICABLE

First Choice Next group provider ID NPI

Name

Street address

City State ZIP

INDIVIDUAL PROVIDER INFORMATION

ADD PROVIDERS (New providers must complete First Choice Next credentialing before they will be added as participating providers. Forms are available at **www.firstchoicenext.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 First Choice 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

Street address 2

Street address 3

City State ZIP

Phone Fax Email

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.)

CHANGE OF OWNERSHIP

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

Effective date of ownership

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

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