AmeriHealth NEW JERSEY

Reference:
Date received:

Please mail or fax this change form and supporting document to:
Network Administration
AmeriHealth New Jersey
P.O. Box 41431, Philadelphia, PA
19101-1431 Fax 215-238-2275

Non-Participating Provider Change Form

Current practice information		
This change affects: ☐ Group practice ☐ Individual physician		
(Group practice) or (Individual physician) name:		
(Group Practice) or (Individual Physician) provider number:		
HMO ID #:	PPO ID #:	PHONE #:
Contact person: *(Change will not be completed without signature)*	Authorizing signature: *(Physician/office manager signature required)*	
Effective date of change	Today's date	

Provider change information

Provide complete information – Your request will be processed for the HMO & PPO line of business. **Changes will be effective within 30 days**.

If any of these changes result in a change on your W-9, you must submit a copy of your W-9 Form with this change form.

Type of change: ☐ Adding a practice ☐ Adding an office location ☐ Telephone ☐ Name change only
☐ Joining a practice ☐ Changing an office location ☐ Fax ☐ Tax ID change

Previous office information			**New office information**		
Name:			Name:		
Street Address:			Street Address:		
City:	State:	ZIP:	City:	State:	ZIP:
Telephone:	Fax:		Telephone:	Fax:	
HMO group practice provider:			HMO group practice provider:		
PBS group practice provider:			PBS group practice provider:		

Physician Members – Please check each as an Add or a Delete to your practice.		
1.Name (last, first, middle):	Individual provider ID#:	☐ ADD ☐ DELETE
	NPI:	NPI eff. date:
Degree:	Taxonomy code:	
2 .Name (last, first, middle):	Individual provider ID#:	☐ ADD ☐ DELETE
	NPI:	NPI eff. date:
Degree:	Taxonomy code:	
3 .Name (last, first, middle):	Individual provider ID#:	☐ ADD ☐ DELETE
	NPI:	NPI eff. date:
Degree:	Taxonomy code:	
3 .Name (last, first, middle):	Individual provider ID#:	☐ ADD ☐ DELETE
	NPI:	NPI eff. date:
Degree:	Taxonomy code:	

Billing location				
Street Address 1:			Telephone:	Fax:
Street Address 2:			Federal tax ID #:	
City:	State:	ZIP:		

Change of ownership (requires npi certification form)	
Legal business name of new owner (last, first, middle):	Degree:
Projected effective date of change of ownership:	Tax ID # of potential new owner (requires a new W-9 Form):
Please provide a brief explanation of change/request:	