

# CareSource Provider/Group Change Request Form

<b>Date:</b> _____  <b>PR Representative:</b> _____	<input type="checkbox"/> <b>Adding a Provider</b> (Adding a provider to a participating group) <input type="checkbox"/> <b>Deleting a Provider</b> (Deleting a provider from a participating group) <input type="checkbox"/> <b>Changing Demographics</b> (Ex. Practice location change, specialty change, NPI/Phone/Fax Change, Product Add/Delete, Capacity, Restrictions)
<i>Details regarding any of these changes can be placed in "Notes" section on the last page</i>	
Group IRS Name	
Group DBA Name	
Group TIN	
Group NPI	
Group Medicare #	
Group Medicaid #	
Product: Medicaid and/or SNP	<input type="checkbox"/> Medicaid only <input type="checkbox"/> SNP Only <input type="checkbox"/> Medicaid and SNP
Please indicate if you are any of the following:	<input type="checkbox"/> FQHC <input type="checkbox"/> RHC <input type="checkbox"/> QFPP
Contact Name	
Contact Phone	
Contact Email	
<b>Contract</b>	
Signatory Name	
Signatory Title	
Signatory Email	
Mailing Address, City, St, Zip	
Remit Name: Address, City, St, Zip	
<b>For Internal Use Only</b> Medicaid Agreement ID: Medicare Agreement ID: IPA:	

Provider (Example)		Deg.			
John Doe (SAMPLE)		MD			
Address			City	ST/County	Zip
123 Main St			Anywhere	Ohio	45123
Phone	Fax	NPI #	CAQH#	Medicaid #	Medicare #
937-555-1212	937-555-1212	1231231291	123456	1234567	1234567
Specialty		PCP? Y/N	If Yes, Capacity 100	Age Restrictions? (18 yrs & older)	Language(s)
Family Practice		Y	2000	18 & older	English, Spanish

Provider #1		Deg.			
Address			City	ST	Zip
Phone	Fax	NPI #	CAQH#	Medicaid #	Medicare #
Specialty		PCP? Y/N	If Yes, Capacity? (Min. 50)	Age Restrictions? (18 yrs & older)	Language(s)

Provider #2		Deg.			
Address			City	ST	Zip
Phone	Fax	NPI #	CAQH#	Medicaid #	Medicare #
Specialty		PCP? Y/N	If Yes, Capacity? (Min. 50)	Age Restrictions? (18 yrs & older)	Language(s)

# CareSource Provider/Group Change Request Form

<b>Provider #3</b>		<b>Deg.</b>			
<b>Address</b>			<b>City</b>	<b>ST</b>	<b>Zip</b>
<b>Phone</b>	<b>Fax</b>	<b>NPI #</b>	<b>CAQH#</b>	<b>Medicaid #</b>	<b>Medicare #</b>
<b>Specialty</b>		<b>PCP? Y/N</b>	<b>If Yes, Capacity? (Min. 50)</b>	<b>Age Restrictions? (18 yrs &amp; older)</b>	

<b>Provider #4</b>		<b>Deg.</b>			
<b>Address</b>			<b>City</b>	<b>ST</b>	<b>Zip</b>
<b>Phone</b>	<b>Fax</b>	<b>NPI #</b>	<b>CAQH#</b>	<b>Medicaid #</b>	<b>Medicare #</b>
<b>Specialty</b>		<b>PCP? Y/N</b>	<b>If Yes, Capacity? (Min. 50)</b>	<b>Age Restrictions? (18 yrs &amp; older)</b>	

<b>Provider #5</b>		<b>Deg.</b>			
<b>Address</b>			<b>City</b>	<b>ST</b>	<b>Zip</b>
<b>Phone</b>	<b>Fax</b>	<b>NPI #</b>	<b>CAQH#</b>	<b>Medicaid #</b>	<b>Medicare #</b>
<b>Specialty</b>		<b>PCP? Y/N</b>	<b>If Yes, Capacity? (Min. 50)</b>	<b>Age Restrictions? (18 yrs &amp; older)</b>	

**NOTES:**

**Important:** Please include W-9 and ensure all CAQH applications are updated and accurate to ensure timely processing of providers.

**Participating Providers:** Email form to: [providermaintenance@caresource.com](mailto:providermaintenance@caresource.com)

**Non-Participating Providers:** Fax form to (937) 531-3910