CareSource Provider/Group Change Request Form

Date: _____ PR Representative: _____	☐ Add a Provider(Adding a provider to a participating group) ☐ Delete a Provider(Deleting a provider from a participating group) ☐ Demographic Change(Ex. Practice location change, specialty change, NPI/Phone/Fax Change, Product Add/Delete, Capacity, Restrictions) *Details regarding any of the above changes can be placed in Notes on Page 2*								
Group IRS Name									
Group DBA									
Group TIN									
Group NPI									
Group Medicare #									
Group Medicaid #									
Product: Medicaid and/or SNP (Medicare)	☐ Medicaid Only	☐ Medicaid and SNP	☐ SNP Only	☐ My Care	☐ Just4Me	☑ All Products			
Please indicate if you are any of the following:	☐ FQHC	☐ RHC	☐ QFPP	☐ CMHC					
Office Contact									
Contact Name									
Contact Phone									
Contact Email									
Contract									
Signatory Name									
Signatory Title									
Signatory Email									
Address									
Remit Name									
Remit	Street		City		State		Zip		
Mailing ☐ Same as above	Street		City		State		Zip		
Contractual Updates ☐ Same as above	Street		City		State		Zip		

For Internal Use Only: Medicaid Agreement ID _____Base Contract Choreo ID:_____ _____

For Internal Use Only: Medicare Agreement ID _____

Provider Information

Name/Deg	Street Address	City	State /County	Zip + 4	Phone	Fax	NPI #	CAQH#	Medicaid #	Medicare #	Specialty	PCP ? Y/N	If Yes, Capacity ?	Age Restrictions
John Doe MD (SAMPLE)		Anywhere	OH/Montgomery	45123-1234	937-555-1212	937-555-1212	1231231291	123456	1234567	1234567	FP	Y	100	

NOTES:

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

Return to: Your CareSource Provider Relations Representative; or, send to providermaintenance@CareSource.com or fax to 937-396-3076