CareSource Provider/Group – Hierarchy Change Request Form

Date: _____ PR Rep: _____	☐ Adding a Provider (Adding a provider to a participating group) ☐ Deleting a Provider (Deleting a provider from a participating group) ☐ Changing Demographics (Ex. Practice location change, specialty change, NPI/Phone/Fax Change, Capacity, Restrictions) ***Details regarding any of the above changes can be placed in NOTES section on the last page***							
Group IRS Name								
Group DBA								
Group TIN								
Group NPI								
Group Medicare #								
Group Medicaid #								
Product:	☐ Medicaid-OH ☐ MyCare-OH ☐ Just4Me-OH ☐ MedicareAdv-OH ☐ CTP-OH ☐ Just4Me-KY ☐ MedicareAdv-KY ☐ Just4Me-IN ☐ MedicareAdv-IN ☐ Medicaid-IN (HHW/HIP) ☐ Just4Me-WV ☐ Medicaid-WV							
Office Contact								
Contact Name								
Contact Phone								
Contact Email								
Please indicate if you are:	☐ FQHC ☐ RHC ☐ QFPP ☐ CMHC							
Contract								
Signatory Name (Individual who is legally authorized to sign documents)								
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**	

REMINDER: For Indiana Medicaid, PMPs are permitted no more than two service locations and must identify capacity.

Provider Information

Name	Deg.	Address	City	ST	Zip	County	Phone	Fax	NPI #	CAQH #	Medicaid #	Medicare #	Specialty	PCP? Y/N	If Y Capacity	Age Restrictions (18 yrs & older)	Race/ Ethnicity	Gender Restrictions
John Doe (SAMPLE)	MD	123 Main St	Anywhere	OH	45123	Greene	937-555-1212	937-555-1212	1231231291		1234567	1234567	FP	Y	100			

***** Race/Ethnicity = Asian, Black or African American. Hispanic or Latino, American Indian, White, Other, Choose Not to Answer**

Notes:	

Please insert rows if more lines are needed.

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

Return to: Providermaintenance@caresource.com OR Fax to (937) 396-3076