CareSource Provider/Group – Hierarchy Change Request Form

Date: _____ PR Rep: _____	☐ Add New Contract/Amendment ☐ 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, National Provider Identifier (NPI)/Phone/Fax Change, Capacity, Restrictions)		
	Details regarding any of the above changes can be placed in the NOTES section on the last page.		
Group Internal Revenue Service (IRS) Name (Must Match Line 1 (one) on W-9)			
Group Does Business As (DBA)			
Group Taxpayer Identification Numbers (TIN)		Group NPI	
Group Taxonomies		Provider Group Website (if applicable)	
Group Medicare Number		Group Medicaid Number Note: A valid Medicaid# is REQUIRED for any Medicaid Product	
Product	☐ AR PASSE ☐ FL TRICARE* ☐ GA TRICARE* ☐ GA D-SNP ☐ GA D-SNP+ ☐ GA Medicaid ☐ GA Marketplace	☐ IN Medicaid (HHW) ☐ IN Medicaid (HIP) ☐ IN Marketplace ☐ MA Senior Care ☐ MA One Care ☐ NV Marketplace ☐ NV Medicaid	☐ OH FIDE-SNP ☐ OH Marketplace ☐ OH Medicaid ☐ WI Marketplace** ☐ WV Marketplace
	*If requesting TRICARE line of business, please provide Facility ID: _____ **Plans issued by Common Ground Healthcare Cooperative		
Languages fluently spoken in office other than English (please specify).		Has any provider ever been excluded from Medicaid or Medicare? (If yes, please explain and provide dates.)	
American Sign Language (Y/N)		Medical Interpreter (Y/N)	
Office Contact			
Contact Name		Contact Phone	

Contact Email								
Please Indicate If You Are:	☐ FQHC ☐ Multi-Specialty/Single Specialty Group		☐ RHC ☐ Individual		☐ CMHC ☐ Ancillary		☐ Facility	
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**	

Provider #1	**Deg.**	**Gender**	**Race/Ethnicity*** (*Race/Ethnicity = Asian, Black or African American, Hispanic or Latino, American Indian, White, Other, Choose Not to Answer)	**Office Phone**	**Office Fax**	**Languages Spoken**

Street Address	**City/County**	**State**	**ZIP**	**Are you: Telemedicine/Locum Tenens/ Hospital-Based Physician/Hospitalist?** (Please Specify Below)	**Telemedicine Presentation Site? (Y/N)**

Practitioner Phone	**Practitioner Fax**	**Practitioner Email**	**CAQH #**	**NPI**	**Medicaid/IHCP #**	**Medicare #**	**DEA/CSR #**	**License #/or ABA Cert # and State**

Specialty	**Board Certified?** (Please Specify Board)	**PCP/PMP? (Y/N)**	**IN HHW PMP Capacity? (Min. 50)**	**IN HIP PMP Capacity? (Min. 50)**	**Cultural Competency (Y/N)**	**Competency Training Name**	**Serve CSHCN? (Y/N)**

If asking for TRICARE products: Does provider have previous military service? Yes or No NOTE: If yes, please provide branch of U.S. Military Armed Forces		**Does provider currently work at a VA facility? If yes, we cannot add to network.** NOTE: Per contractual requirements, providers who are employed with the VA are not eligible to participate in this network. Please remove TRICARE from the application and move forward or exit the application if it was only for TRICARE.
Yes/No	**Branch of U.S. Military Armed Forces:**	

Hospital/Delivery Privileges or Arrangements	**Gender Restrictions**	**Age Range (i.e., 0-21, 18+)**	**Accepting New Patients (Y/N)**	**Taxonomy**	**Public Transportation Route? (Y/N)**

NP Specialty-Supported? (Y/N)	**Do NP/PAs practice here?**	**Office Hours**						
		Mon	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**
Accessibility Accommodations (please list all accommodations, i.e., wide entry, wheel chair access, etc.)	**Do you have rendering providers? (Y/N)** NOTE: If yes, please provide a spreadsheet with each rendering provider's information.							

☐ Adding a Provider (Adding provider to a participating group) ☐ Deleting a Provider (Deleting provider from a participating group)

Provider #2	**Deg.**	**Gender**	**Race/Ethnicity*** (*Race/Ethnicity = Asian, Black or African American, Hispanic or Latino, American Indian, White, Other, Choose Not to Answer)	**Office Phone**	**Office Fax**	**Languages Spoken**

Street Address	**City/County**	**State**	**ZIP**	**Are you: Telemedicine/Locum Tenens/ Hospital-Based Physician/Hospitalist?** (Please Specify Below)	**Telemedicine Presentation Site? (Y/N)**

Practitioner Phone	**Practitioner Fax**	**Practitioner Email**	**CAQH #**	**NPI**	**Medicaid/IHCP #**	**Medicare #**	**DEA/CSR #**	**License #/or ABA Cert # and State**

Specialty	Board Certified? (Please Specify Board)	PCP/PMP? (Y/N)	IN HHW PMP Capacity? (Min. 50)	IN HIP PMP Capacity? (Min. 50)	Cultural Competency (Y/N)	Competency Training Name	Serve CSHCN? (Y/N)

If asking for TRICARE products: Does provider have previous military service? Yes or No NOTE: If yes, please provide branch of U.S. Military Armed Forces		Does provider currently work at a VA facility? If yes, we cannot add to network. NOTE: Per contractual requirements, providers who are employed with the VA are not eligible to participate in this network. Please remove TRICARE from the application and move forward or exit the application if it was only for TRICARE.
Yes/No	Branch of U.S. Military Armed Forces:	

Hospital/Delivery Privileges or Arrangements	Gender Restrictions	Age Range (i.e., 0-21, 18+)	Accepting New Patients (Y/N)	Taxonomy	Public Transportation Route? (Y/N)

NP Specialty-Supported? (Y/N)	Do NP/PAs practice here?	Office Hours						
		Mon	Tues	Wed	Thur	Fri	Sat	Sun
Accessibility Accommodations (please list all accommodations, i.e., wide entry, wheel chair access, etc.)	Do you have rendering providers? (Y/N) NOTE: If yes, please provide a spreadsheet with each rendering provider's information.							

☐ Adding a Provider (Adding provider to a participating group) ☐ Deleting a Provider (Deleting provider from a participating group)

Provider #3	Deg.	Gender	Race/Ethnicity* (*Race/Ethnicity = Asian, Black or African American, Hispanic or Latino, American Indian, White, Other, Choose Not to Answer)	Office Phone	Office Fax	Languages Spoken

Street Address	City/County	State	ZIP	Are you: Telemedicine/Locum Tenens/ Hospital-Based Physician/Hospitalist? (Please Specify Below)	Telemedicine Presentation Site? (Y/N)

Practitioner Phone	Practitioner Fax	Practitioner Email	CAQH #	NPI	Medicaid/IHCP #	Medicare #	DEA/CSR #	License #/or ABA Cert # and State

Specialty	Board Certified? (Please Specify Board)	PCP/PMP? (Y/N)	IN HHW PMP Capacity? (Min. 50)	IN HIP PMP Capacity? (Min. 50)	Cultural Competency (Y/N)	Competency Training Name	Serve CSHCN? (Y/N)

If asking for TRICARE products: Does provider have previous military service? Yes or No NOTE: If yes, please provide branch of U.S. Military Armed Forces		Does provider currently work at a VA facility? If yes, we cannot add to network. NOTE: Per contractual requirements, providers who are employed with the VA are not eligible to participate in this network. Please remove TRICARE from the application and move forward or exit the application if it was only for TRICARE.
Yes/No	Branch of U.S. Military Armed Forces:	

Hospital/Delivery Privileges or Arrangements	Gender Restrictions	Age Range (i.e., 0-21, 18+)	Accepting New Patients (Y/N)	Taxonomy	Public Transportation Route? (Y/N)

NP Specialty-Supported? (Y/N)	Do NP/PAs practice here?	Office Hours						
		Mon	Tues	Wed	Thur	Fri	Sat	Sun
Accessibility Accommodations (please list all accommodations, i.e., wide entry, wheel chair access, etc.)	Do you have rendering providers? (Y/N) NOTE: If yes, please provide a spreadsheet with each rendering provider's information.							

☐ Adding a Provider (Adding provider to a participating group) ☐ Deleting a Provider (Deleting provider from a participating group)

Notes:	Durable Medical Equipment (DME):
	Counties Served:
	Specialized Services (breast pump, diabetes supplies, etc.):

	Home Health:
	Counties Served:
	Specialized Services (therapy, wound care, etc.):

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. If an OB/GYN or PMP in Indiana, please include your scope of practice. Arkansas physicians must also complete the CareSource PASSE Arkansas Attestation and the CCVS Authorization and Release for CareSource PASSE.

If the provider being added is not contracted or needs an IRS name/TIN change, please complete a new contract request/addendum at CareSource.com.

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