

CareSource Provider/Group – Hierarchy Change Request Form

| Date: PR Rep: | Deleting a Provider | Adding provider to a participation (Deleting a provider from a pain phics (Ex. Practice location cha | rticipating group) | one/Fax Change, Capacity | , Restrictions) | | | | |
|--|----------------------------|--|--------------------|--------------------------|-----------------|--|--|--|--|
| | _ | instrume change Details regarding any of the above changes can be placed in NOTES section on the last page | | | | | | | |
| Group IRS Name (Must Match Line 1 (one) on W-9) | | | • | | | | | | |
| Group DBA | | | | | | | | | |
| Group TIN | | | | | | | | | |
| Group NPI | | | | | | | | | |
| Group Medicaid # NOTE- A Valid Medicaid # is REQUIRED for any Medicaid Product and/or MyCare-OH | | | | | | | | | |
| Product: | ☐Medicaid – G | 6A | | | | | | | |
| Provider Group Website (if applicable) | | | | | | | | | |
| Office Contact | | | | | | | | | |
| Contact Name | | | | | | | | | |
| Contact Phone | | | | | | | | | |
| Contact Email | | | | | | | | | |
| Please indicate if you are: | FQHC RF Substance Use Diso | HC |] CMHC r (OUD) | ent Program (OTP) | | | | | |
| Contract | | | | | | | | | |
| Signatory Name (Individual who is legally authorized to sign documents) | | | | | | | | | |
| Signatory Title | | | | | | | | | |
| Signatory Email | | | | | | | | | |
| Address | | | | | | | | | |
| Remit Name | | T | | 1 | | | | | |
| Remit | Street | | City | State | Zip | | | | |
| Mailing Same as above | Street | | City | State | Zip | | | | |
| Contractual Updates Same as above | Street | | City | State | Zip | | | | |

| Provider | | Deg. | Telemedicine Services Provided? (Y/N) | | |) Telem | Telemedicine Presentation Site? (Y/N) | | | Additional Languages | | |
|---|-------------|---------------------------------------|---------------------------------------|----------------|--------------------------|---------------------------------------|--|-------------------------------|----------------------|---------------------------|-------|-----|
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Address | | | City/County | | | | Stat | e | | Zip | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Phone | Fa | ıx | NPI# | | CAQH# | | | Medicaid/IHCP # | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Smaaialtu | | Board Ce | ertified? (Please Specify | | | | Cultural Compentency (Y/N) Compentency | | | Nome | | |
| Specialty | | | Boards) | PCP? Y/N | /N If PCP, List Capacity | | | IN) | Compen | tency Training | ivame | |
| | | | | | | | | | | | | |
| Age Restrictions? | (18 vrs & o | lder) | Race/Ethnicity | Gender Restric | tions | | | | Office Hours | | | |
| Age nestrictions. | (10)10 4 0 | idely | nacy Edinioley | Gender Resure | | Mon | Tues | Wed | Thur | Fri | Sat | Sun |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Provider #1 Deg. | | Telemedicine Services Provided? (Y/N) | | |) Telem | Telemedicine Presentation Site? (Y/N) | | | Additional Languages | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Address | | | City/County | | | | State | | | Zip | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Phone | Fa | ıx | NPI # | CAQH# | | | | Medicaid/IHCP # | | | | |
| | | | | | | | | | | | | |
| | | | | | • | | | | | | | |
| Specialty | | Board Ce | ertified? (Please Specify Boards) | | | List Canacity | | Cultural Compentency (Y/N) | | Compentency Training Name | | |
| Specialty | | PCP? Y/N If PCP, List Capacity | | (1/ | (17N) Compentency | | tericy framing | IVallic | | | | |
| | | | | | | | | | | | | |
| Age Restrictions? (18 yrs & older) Race/Ethnicity | | Gender Restrictions | | | Office Hours | | | | | | | |
| | | | | | Mon | Tues | Wed | Thur | Fri | Sat | Sun | |
| | | | | | | | | | | | | |
| | | | | | | 1 | İ | İ | | İ | 1 | |

| Provider #2 | | Deg. | Telemedicine Services Provided? (Y/N) | | |) Telem | Telemedicine Presentation Site? (Y/N) | | | Additional Languages | | |
|---|-------------|---------------------------------|---------------------------------------|--------------------------------|---------------------|---------------------------------------|--|-----------------|----------------|----------------------|-------|-----|
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Address | | | City/County | | | | Stat | e | | Zip | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Phone | Fa | ax | NPI # | CAQH# | | | | | Medicaid/IHCP | # | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Smaaialtu | | Board Co | ertified? (Please Specify | | | | Cultural Compentency | | | Nome | | |
| Specialty | | | Boards) | PCP? Y/N | II PCP, | LIST Capacity | t Capacity (Y/N) | | | tency Training | ivame | |
| | | | | | | | | | | | | |
| Age Restrictions? | (18 vrs & o | lder) | Race/Ethnicity | Gender Restric | tions | | Office Hours | | | | | |
| - Age need need need need need need need ne | (20)10 010 | | mace, zaminere, | | | Mon | Tues | Wed | Thur | Fri | Sat | Sun |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Provider #3 Deg. | | Telemedicine S | ervices F | Provided? (Y/N) |) Telem | Telemedicine Presentation Site? (Y/N) | | | Additional Lar | nguages | | |
| | | | | | | | | | | | | |
| | | | ou to | | | | | | | | | |
| Address | | | City/County | | | | State | | | Zip | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Phone | Fa | эх | NPI # | CAQH# | | | | Medicaid/IHCP # | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Specialty | | Board Ce | ertified? (Please Specify Boards) | PCP? Y/N If PCP, List Capacity | | | Cultural Compentency (Y/N) Compentency | | tency Training | y Training Name | | |
| Specialty Boards) | | rer: 1714 II rer, List capacity | | (1) | (1714) Compensation | | tency maning | itanic | | | | |
| | | | | | | | | | | | | |
| Age Restrictions? (18 yrs & older) Race/Ethnicity | | Gender Restrictions | | | Office Hours | | | | | | | |
| , | | | | | Mon | Tues | Wed | Thur | Fri | Sat | Sun | |
| | | | | | | | | | | | | |
| | | | | | | | İ | İ | | | | |

| Notes: | | | |
|--------|--|--|---|
| | | | ļ |
| | | | |
| | | | |
| | | | |
| | | | |

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

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.

GA-P-0548

DCH Approved: 09/20/2018