# CareSource Provider/Group – Hierarchy Change Request Form

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Date: _____<br><br>PR Rep:<br>_____ | ☐ Adding a Provider (Adding provider to a participating group)<br>☐ Deleting a Provider (Deleting a provider from a participating group)<br>☐ Changing Demographics (Ex. Practice location change, specialty change, NPI/Phone/Fax Change, Capacity, Restrictions)<br>☐ IRS Name Change<br>***Details regarding any of the above changes can be placed in NOTES section on the last page*** | | | | | | | | |
| Group IRS Name<br>(Must Match Line 1 (one) on W-9) | | | | | | | | | |
| Group DBA | | | | | | | | | |
| Group TIN | | | | | | | | | |
| Group NPI | | | | | | | | | |
| Group Medicaid #<br>NOTE- A Valid Medicaid # is REQUIRED for any Medicaid Product and/or MyCare-OH | | | | | | | | | |
| Product: | ☐ Medicaid – GA | | | | | | | | |
| Provider Group Website<br>(if applicable) | | | | | | | | | |
| **Office Contact** | | | | | | | | | |
| Contact Name | | | | | | | | | |
| Contact Phone | | | | | | | | | |
| Contact Email | | | | | | | | | |
| Please indicate if you are: | ☐ FQHC ☐ RHC ☐ QFPP ☐ CMHC<br>☐ Substance Use Disorder(SUD)/Opioid Use Disorder (OUD) ☐ Opioid Treatment Program (OTP) | | | | | | | | |
| **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 | Deg. | Telemedicine Services Provided? (Y/N) | Telemedicine Presentation Site? (Y/N) | Additional Languages |
|---|---|---|---|---|
| | | | | |

| Address | City/County | State | Zip |
|---|---|---|---|
| | | | |

| Phone | Fax | NPI # | CAQH# | Medicaid/IHCP # |
|---|---|---|---|---|
| | | | | |

| Specialty | Board Certified? (Please Specify Boards) | PCP? Y/N | If PCP, List Capacity | Cultural Compentency (Y/N) | Compentency Training Name |
|---|---|---|---|---|---|
| | | | | | |

| Age Restrictions? (18 yrs & older) | Race/Ethnicity | Gender Restrictions | Office Hours | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | Mon | Tues | Wed | Thur | Fri | Sat | Sun |
| | | | | | | | | | |

| Provider #1 | Deg. | Telemedicine Services Provided? (Y/N) | Telemedicine Presentation Site? (Y/N) | Additional Languages |
|---|---|---|---|---|
| | | | | |

| Address | City/County | State | Zip |
|---|---|---|---|
| | | | |

| Phone | Fax | NPI # | CAQH# | Medicaid/IHCP # |
|---|---|---|---|---|
| | | | | |

| Specialty | Board Certified? (Please Specify Boards) | PCP? Y/N | If PCP, List Capacity | Cultural Compentency (Y/N) | Compentency Training Name |
|---|---|---|---|---|---|
| | | | | | |

| Age Restrictions? (18 yrs & older) | Race/Ethnicity | Gender Restrictions | Office Hours | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | Mon | Tues | Wed | Thur | Fri | Sat | Sun |
| | | | | | | | | | |

| Provider #2 | Deg. | Telemedicine Services Provided? (Y/N) | Telemedicine Presentation Site? (Y/N) | Additional Languages |
|---|---|---|---|---|
| | | | | |

| Address | City/County | State | Zip |
|---|---|---|---|
| | | | |

| Phone | Fax | NPI # | CAQH# | Medicaid/IHCP # |
|---|---|---|---|---|
| | | | | |

| Specialty | Board Certified? (Please Specify Boards) | PCP? Y/N | If PCP, List Capacity | Cultural Compentency (Y/N) | Compentency Training Name |
|---|---|---|---|---|---|
| | | | | | |

| Age Restrictions? (18 yrs & older) | Race/Ethnicity | Gender Restrictions | Office Hours | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | Mon | Tues | Wed | Thur | Fri | Sat | Sun |
| | | | | | | | | | |

| Provider #3 | Deg. | Telemedicine Services Provided? (Y/N) | Telemedicine Presentation Site? (Y/N) | Additional Languages |
|---|---|---|---|---|
| | | | | |

| Address | City/County | State | Zip |
|---|---|---|---|
| | | | |

| Phone | Fax | NPI # | CAQH# | Medicaid/IHCP # |
|---|---|---|---|---|
| | | | | |

| Specialty | Board Certified? (Please Specify Boards) | PCP? Y/N | If PCP, List Capacity | Cultural Compentency (Y/N) | Compentency Training Name |
|---|---|---|---|---|---|
| | | | | | |

| Age Restrictions? (18 yrs & older) | Race/Ethnicity | Gender Restrictions | Office Hours | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | Mon | Tues | Wed | Thur | Fri | Sat | Sun |
| | | | | | | | | | |

***** 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.**