

CareSource Provider/Group – Hierarchy Change Request Form

Date:	Deleting a Provider	Adding provider to a participating gro (Deleting a provider from a participa phics (Ex. Practice location change, s	ting group)	Eav Change Canacity Postrictions
PR Rep:	☐ IRS Name Change	y of the above changes can be pla		
Group IRS Name (Must Match Line 1 (one) on W-9)				
Group DBA				
Group TIN				
Group NPI				
Group Medicare # (If Applicable)				
Group Medicaid # NOTE- A Valid Medicaid # is REQUIRED for any Medicaid Product and/or MyCare-OH				
Product:		edicaid – GA 🔲 HIP– IN 🔲 HHV Marketplace - KY 📗 Marketplace – WV		GA, IN, KY DSNP-OH, GA, IN, KY Marketplace - GA MyCare - OH
Provider Group Website (if applicable)				
Office Contact				
Contact Name				
Contact Phone				
Contact Email				
Please indicate if you are:	FQHC RI Substance Use Diso	HC		rogram (OTP)
Contract				
Signatory Name (Individual who is legally authorized to sign documents)				
Signatory Title				
Signatory Email				
Address				
Remit Name				
Remit	Street	City	Stat	e Zip

Mailing	☐ Sa	ame as above	Street				City			9	State		z	ip	
Contractual Updat	tes 🗆 s	ame as above	Street				City			9	State		z	ip	
Provid	der		Deg.	Telemedicine	Services	Provided? (Y/N)		Telen	nedicine Prese	ntation Si	ite? (Y/	N)	Additiona	Langua	ages
						(1)					(1)	,			
	Δ	ddress			City/Cour	nty			Sta	ite			Z	ip	
Phone		Fax	NPI #		CAQH#				Medicaio	d/IHCP#			Med	care #	
Coordala		Board Cer	tified? (Please Specify	DCD2 V/N	It DCD	List Compaits	Cu		mpentency		,		Tuninina Na		
Specialty			Boards)	PCP? Y/N	IT PCP	P, List Capacity		(Y,	/N)			Compentency	Training Na	me	
Age Restrictions?	(18 yrs &	older)	Race/Ethnicity	Gender Restri	ctions					Office H	Hours				
						Mon	Т	Tues	Wed	Thu	ur	Fri	Sat		Sun
		ing provider to	o a participating group)						Deleting	; a Provide	er (Dele	ting a provide	er from a pa	ticipati	ing group)
Provide	er #1		Deg.	Telemedicine	Services	Provided? (Y/N)		Telen	nedicine Prese	ntation Si	ite? (Y/	N)	Additiona	Langua	ages
	Δ	ddress			City/Cour	ntv			Sta	nte				ip	
														·	
Phone		Fax	NPI #		CAQH#				Medicaio	d/IHCP#			Medi	care #	
		Board Cer	tified? (Please Specify				Cu		mpentency						
Specialty			Boards)	PCP? Y/N	If PCP	P, List Capacity		(Y,	/N)		(Compentency	Training Na	me	
Age Restrictions?	(18 yrs &	older)	Race/Ethnicity	Gender Restric	ctions					Office F	Hours				
Age Restrictions?	(18 yrs &	older)	Race/Ethnicity	Gender Restric	ctions	Mon	Т	Tues	Wed	Office H		Fri	Sat		Sun
Age Restrictions?	(18 yrs &	older)	Race/Ethnicity	Gender Restric	ctions	Mon	T	Γues	Wed			Fri	Sat		Sun

Provide	er #2	Deg.	Telemedicine S	Services I	Provided? (Y/N)	Telen	edicine Prese	entation Site? (Y,	/N)	Additional Lang	guages
	Address	<u> </u>	С	ity/Coun	ity		Sta	ate		Zip	
Phone	Fax	NPI#		CAQH#			Medicai	d/IHCP#		Medicare	#
Constales	Board Ce	rtified? (Please Specify	DCD2 V/N	It Den			mpentency		.	T	
Specialty		Boards)	PCP? Y/N	IT PCP	, List Capacity	(Y,	/N)		Compentency	Training Name	
Age Restrictions?	(18 yrs & older)	Race/Ethnicity	Gender Restrict	tions				Office Hours			
					Mon	Tues	Wed	Thur	Fri	Sat	Sun
Adding a Provi	der (Adding provider t	o a participating group)	L		l l		Deleting	a Provider (Dele	ting a provide	r from a particip	ating group)
Provide	er #3	Deg.	Telemedicine S	Services I	Provided? (Y/N)	Telen	nedicine Prese	entation Site? (Y	/N)	Additional Lang	guages
	Address		C	ity/Coun	ity		Sta	ate		Zip	
Phone	Fax	NPI#		CAQH#			Medicai	d/IHCP#		Medicare	#
	Board Ce	rtified? (Please Specify					mpentency				
Specialty Boards)		Boards)	PCP? Y/N If PCP, List Capacity		(Y	(Y/N) C			mpentency Training Name		
Age Restrictions?	(18 yrs & older)	Race/Ethnicity	Gender Restrict	tions				Office Hours			
Age Restrictions?	(18 yrs & older)	Race/Ethnicity	Gender Restrict	tions	Mon	Tues	Wed	Office Hours Thur	Fri	Sat	Sun
Age Restrictions?	(18 yrs & older)	Race/Ethnicity	Gender Restrict	tions	Mon	Tues	Wed		Fri	Sat	Sun

Notes:			

*** 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.