



CareSource Provider/Group – Hierarchy Change Request Form

| | | | | | | | | | |
|--|--|---------------|--|--------------|--|--------------|--|------------|--|
| Date: _____ PR Rep: _____ | <input type="checkbox"/> Adding a Provider (Adding provider to a participating group) <input type="checkbox"/> Deleting a Provider (Deleting a provider from a participating group) <input type="checkbox"/> Changing Demographics (Ex. Practice location change, specialty change, NPI/Phone/Fax Change, Capacity, Restrictions) <input type="checkbox"/> IRS Name Change <p style="color: red; font-weight: bold;"><i>Details regarding any of the above changes can be placed in NOTES section on the last page</i></p> | | | | | | | | |
| 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: | <input type="checkbox"/> Medicaid - OH <input type="checkbox"/> MyCare - OH <input type="checkbox"/> Marketplace - OH <input type="checkbox"/> MedicareAdv - OH <input type="checkbox"/> CTP - OH <input type="checkbox"/> Marketplace - KY <input type="checkbox"/> Marketplace – IN <input type="checkbox"/> Marketplace – WV | | | | | | | | |
| Provider Group Website (if applicable) | | | | | | | | | |
| Office Contact | | | | | | | | | |
| Contact Name | | | | | | | | | |
| Contact Phone | | | | | | | | | |
| Contact Email | | | | | | | | | |
| Please indicate if you are: | <input type="checkbox"/> FQHC <input type="checkbox"/> RHC <input type="checkbox"/> QFPP <input type="checkbox"/> CMHC <input type="checkbox"/> Substance Use Disorder(SUD)/Opioid Use Disorder (OUD) <input type="checkbox"/> Opioid Treatment Program (OTP) | | | | | | | | |
| Contract | | | | | | | | | |
| Signatory Name (Individual who is legally authorized to sign documents) | | | | | | | | | |
| Signatory Title | | | | | | | | | |
| Signatory Email | | | | | | | | | |
| Address | | | | | | | | | |
| Remit Name | | | | | | | | | |
| Remit | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Street</td> <td style="width: 25%;"></td> <td style="width: 25%;">City</td> <td style="width: 25%;"></td> <td style="width: 10%;">State</td> <td style="width: 10%;"></td> <td style="width: 10%;">Zip</td> <td style="width: 10%;"></td> </tr> </table> | Street | | City | | State | | Zip | |
| Street | | City | | State | | Zip | | | |

| | | | | |
|--|--------|------|-------|-----|
| Mailing <input type="checkbox"/> Same as above | Street | City | State | Zip |
| Contractual Updates <input type="checkbox"/> 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 # | | | Medicare # | | | |
| Specialty | Board Certified? (Please Specify Boards) | | PCP? Y/N | If PCP, List Capacity | Cultural Competency (Y/N) | | Competency 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 # | | | Medicare # | | | |
| Specialty | Board Certified? (Please Specify Boards) | | PCP? Y/N | If PCP, List Capacity | Cultural Competency (Y/N) | | Competency 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 # | | | Medicare # | | | | |
| | | | | | | | | | | | | |
| Specialty | | Board Certified? (Please Specify Boards) | | PCP? Y/N | If PCP, List Capacity | | Cultural Competency (Y/N) | Competency 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 # | | | Medicare # | | | | |
| | | | | | | | | | | | | |
| Specialty | | Board Certified? (Please Specify Boards) | | PCP? Y/N | If PCP, List Capacity | | Cultural Competency (Y/N) | Competency 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**

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| Notes: | |
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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.