CareSource Provider/Group – Hierarchy Change Request Form

Date: _____ PR Rep: _____	☐ Adding a Provider (Adding provider to a participating group) ☐ Deleting a Provider (Deleting a provider from a participating group) ☐ Changing Demographics (Ex. Practice location change, specialty change, NPI/Phone/Fax Change, Capacity, Restrictions) ☐ IRS Name 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:	☐ Hoosier Healthwise (IN)HHW ☐ Healthy Indiana Program (HIP)							
Provider Group Website (if applicable)								
Office Contact								
Contact Name								
Contact Phone								
Contact Email								
Please indicate if you are:	☐ FQHC ☐ RHC ☐ QFPP ☐ CMHC ☐ 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	HHW Capacity? (Min. 50)	HIP Capacity? (Min 50)	Cultural Compentency (Y/N)	Compentency Training Name
					<100>	<Yes>	<Cultural Comptency 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	HHW Capacity? (Min. 50)	HIP Capacity? (Min 50)	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	HHW Capacity? (Min. 50)	HIP Capacity? (Min 50)	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	HHW Capacity? (Min. 50)	HIP Capacity? (Min 50)	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.