

CareSource Provider/Group – Hierarchy Change Request Form

| Date: | Deleting a Provider Changing Demograp IRS Name Change | • | om a participa tion change, s | | | t y, Restr | ·ictions) |
|--------------------------------------------------------------------------------------------------|-------------------------------------------------------|-----------------------------------|----------------------------------|-------------------|-------------------|-------------------|-----------|
| 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 F | lealthwise (IN)HHW |] Healthy India | ana Program (HIP) | | | |
| Provider Group Website (if applicable) | | | | | | | |
| Office Contact | | | | | | | |
| Contact Name | | | | | | | |
| Contact Phone | | | | | | | |
| Contact Email | | | | | | | |
| Please indicate if you are: | FQHC RH | IC QFPP rder(SUD)/Opioid Use [| CMH [] Disorder (OUD | | ent 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 | |

| Provid | der der | | Deg. | Telemedicine Sen | vices P | Provided? (V/N) | 1 | Telem | adicina Drasant | ation Site? (V | /N) | Additional Lan | GIIAGAS | |
|-------------------|------------------------------|---------------------------------------|---------------------------------------|-------------------------|---------|---------------------------------------|-----------------|---------------------------|-----------------|----------------------|----------------------------|---------------------------------------------|---------------------------|--|
| Frovider Deg. | | relemedicine Serv | Telemedicine Services Provided? (Y/N) | | | Telemedicine Presentation Site? (Y/N) | | | | Additional Languages | | | | |
| | | | | | | | | | | | | | | |
| | Address | | | City | /Coun | ty | | | State | | | Zip | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| Dhana | Farr | | NPI # | CAQH# | | | | As disciding to | | | | | | |
| Phone | Fax | | NPI # | C/ | AQH# | | | Medicaid/IHCP # | | | | | | |
| | | | | | | | | | | | | | | |
| | Board Cer | ified? | | If PCP, List | Н | HW Capacity? | | HIP Capacity? Cultural | | | Compentency | mpentency Compentency Training | | |
| Specialty | (Please Specif | | PCP? Y/N | Capacity | | (Min. 50) | | (Min 50) | | | (Y/N) | Name | | |
| | | | | | | | | | | | | <cultural co<="" td=""><td></td></cultural> | | |
| | | | | | | | | <100> | | <yes></yes> | | Training Nam | ne> | |
| Age Restrictions? | (18 yrs & older) | Race | e/Ethnicity | Gender Restriction | | | | Office Hours | | | | | | |
| | | | | | | Mon | | Tues | Wed | Thur | Fri | Sat | Sun | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| Provider #1 Deg. | | Telemedicine Services Provided? (Y/N) | | |) | Telemedicine Presentation Site? (Y/N) | | | /N) | Additional Lan | guages | | | |
| | | | | | | | | | | | | | | |
| | A44 | | City/County | | | | | | | | | | | |
| Address | | City, | City/County | | | State | | | | Zip | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| Phone | Fax | | NPI # | CA | | | Medicaid/IHCP # | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| Specialty | Board Ceri (Please Specif | | PCP? Y/N | If PCP, List H Capacity | | HW Capacity? (Min. 50) | | HIP Capacity? (Min 50) | | | Cultural Compentency (Y/N) | | Compentency Training Name | |
| Specialty | (i icase specii | , Dodius) | 1 Ci ; 1/N | Capacity | | (1411111. 30) | | | (141111 30) | | (1/14) | 140 | | |
| | | | | | | | | | | | | | | |
| Age Restrictions? | (18 yrs & older) | Race | e/Ethnicity | Gender Restriction | ns | | Office Hours | | | | | | | |
| | | | - | | | Mon | | Tues | Wed | Thur | Fri | Sat | Sun | |
| | | | | | | | | | | | | | | |

| Provide | er #2 | | Deg. | Telemedicine Servi | ces Provided? (Y/N) | Teler | nedicine Presenta | tion Site? (Y/I | V) / | Additional Languages | | |
|-------------------|------------------|-----------|------------|---------------------|---------------------|------------------------------|-------------------|-----------------|------------------------------|----------------------|--------------|--|
| | | | | | | | | | | | | |
| Address | | | City/C | | State | | | Zip | | | | |
| | Address | | | City/C | ounty | | State | | | Zip | | |
| | | | | | | | | | | | | |
| Phone | Fax | | NPI # | CAC | | Medicaid/IF | ICP# | | | | | |
| | | | | | | | | | | | | |
| | Board Cert | ified? | | If PCP, List | F | HIP Capacity? Cultural Compo | | | entency Compentency Training | | | |
| Specialty | (Please Specif | y Boards) | PCP? Y/N | Capacity | (Min. 50) | | | | | N) Name | | |
| | | | | | | | | | | | | |
| Age Restrictions? | (18 yrs & older) | Race | /Ethnicity | Gender Restrictions | | 1 | | Office Hours | | | | |
| | | | | | Mon | Tues | Wed | Thur | Fri | Sat | Sun | |
| | | | | | | | | | | | | |
| | | • | | | 1 | | <u> </u> | • | | | | |
| Provide | Provider #3 Deg. | | | | ces Provided? (Y/N) | Teler | nedicine Presenta | tion Site? (Y/I | N) | Additional Languages | | |
| | | | | | | | | | | | | |
| Address | | | City/C | | State | | | Zip | | | | |
| | | | - | | | | | | - | | | |
| | | | | | | | | | | | | |
| Phone | Fax | | NPI # | CAC | | Medicaid/IF | CP# | | | | | |
| | | | | | | | | | | | | |
| | Board Cert | | | If PCP, List | HHW Capacity? | F | IIP Capacity? | | Compentency | Compente | ncy Training | |
| Specialty | (Please Specif | y Boards) | PCP? Y/N | Capacity | (Min. 50) | | (Min 50) | (| Y/N) | Na | ame | |
| | | | | | | | | | | | | |
| 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: | |
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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. |
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Issue Date: 08/16/2018

IN-P-0528

OMPP Approved: 08/07/2018