



**PROVIDER CHANGE FORM**  
**CURRENT PRACTICE INFORMATION**

Group Practice Name/Individual Name: \_\_\_\_\_  
 (Please Circle One ↑)

Group Practice ID/Individual ID: AMHP ID: \_\_\_\_\_ NPI # \_\_\_\_\_ PPID# \_\_\_\_\_  
 (Please Circle One ↑)

\_\_\_\_\_  
 Contact Person Name (please print clearly) Telephone Fax e-mail address

\_\_\_\_\_  
 Authorizing Signature (physician/office manager) Today's Date Effective Date of Change  
 Change will not be completed without signature

**PROVIDER CHANGE INFORMATION**

Provide Complete Information – This Request will be processed for AmeriHealth Mercy. If any of these changes result in a change on your W-9, you must submit a copy of your W-9 with this change form. PLEASE NOTE: Practitioners must complete AmeriHealth Mercy Credentialing before they will be added to your practice as a participating provider. Refer to the AmeriHealth Mercy Web site for Credentialing Requirements [www.amerhealthmercyhp.com](http://www.amerhealthmercyhp.com)

Type of Change: (Please check all that apply)	<input type="checkbox"/> Adding a Practice	<input type="checkbox"/> Adding an office location	<input type="checkbox"/> Fax change
	<input type="checkbox"/> Joining a Practice	<input type="checkbox"/> Changing an office location	<input type="checkbox"/> Name change only
	<input type="checkbox"/> Telephone change	<input type="checkbox"/> Other (attach documentation)	

PREVIOUS OFFICE INFORMATION			N	EW OFFICE INFORMATION		
AMHP Group Provider ID		NPI		AMHP Group Provider ID		NPI
Name				Name		
Street Address				Street Address		
City	State	Zip		City	State	Zip

**ADD Practitioners** (New Practitioners must complete AmeriHealth Mercy Credentialing before they are added as a participating provider)

1. _____ Last First M.I. Degree	_____ NPI	_____ PPID
2. _____ Last First M.I. Degree	_____ NPI	_____ PPID

**TERMINATE Practitioners** (Please give AmeriHealth Mercy 60 days advance notice when a Practitioner is leaving the group)

1. _____ Last First M.I. Degree	_____ NPI	_____ PPID
2. _____ Last First M.I. Degree	_____ NPI	_____ PPID

**BILLING LOCATION CHANGE**

Street Address 1	Telephone	Fax	e-mail address
Street Address 2	Federal Tax ID (change in Federal ID requires new W-9)		
City	State	Zip	

**CHANGE OF OWNERSHIP**

\_\_\_\_\_ Legal Business Name of New Owner and Federal Tax ID (Requires new W-9) Effective Date of Ownership

**Please Mail or Fax this change form and supporting documents to:**  
**AmeriHealth Mercy Health Plan, Provider Contracting Department 8040 Carlson Rd. Ste. 500 Harrisburg, PA 17112 Fax 717-651-1673**