Practice Profile Update Form
for Amerigroup Kansas, Inc. providers

To update your practice profile, complete the form below and fax it to the Provider Relations department at 1-866-494-5632. If you have any questions or need assistance, please contact your local Provider Relations representative or call 1-800-454-3730.

1. Do not complete the entire form; only fill in sections where your information has changed.
2. You must complete the Provider Information section.
3. Sign and date the form before faxing.

Provider information

Provider name: _____

☐ Practitioner ☐ Group ☐ Facility

Gender: ☐ Female ☐ Male

Specialty: _____ License #: _____

TIN: _____

Group NPI: _____

Group name: _____

NPI: _____

Type of information being updated

Please check **all** that apply:

☐ Billing/remittance information

☐ Location or contact information

☐ Office hours

☐ Provider is terminating.

Effective date of termination: _____

☐ Practice details

☐ PCP details

☐ Other: _____

Practice details

Office hours:

Monday	_____ a.m.	_____ p.m.
Tuesday	_____ a.m.	_____ p.m.
Wednesday	_____ a.m.	_____ p.m.
Thursday	_____ a.m.	_____ p.m.
Friday	_____ a.m.	_____ p.m.
Saturday	_____ a.m.	_____ p.m.
Sunday	_____ a.m.	_____ p.m.

Age range of patients served:

☐ Pediatric ☐ Geriatric

☐ All ages ☐ Other: _____

Languages spoken: _____

Wheelchair accessible? ☐ Yes ☐ No

Primary care provider details

PCPs are **required** to have coverage 24 hours a day, 7 days a week. Please mark your coverage type:

☐ Answering service ☐ Beeper or pager ☐ Answering machine ☐ Other phone number: _____

Are you accepting new patients? ☐ Yes ☐ No

If yes, please explain: _____

Billing information

Please attach a current *W-9* form with this address listed for all billing additions and updates. Changes cannot be processed without a current *W-9* form.

New tax ID number? ☐ Yes ☐ No

Tax ID number: _____ Effective date of change: _____

Billing address: _____

Billing city, state and Zip + 4: _____

Phone number: _____ Fax number: _____

Contact person: _____

New or an additional office locations

☐ New location ☐ Additional location ☐ Update current location

Effective date: _____ Will this be your primary location? ☐ Yes ☐ No

Site name: _____

Site address: _____

Site city, state and Zip + 4: _____

Office manager: _____

Phone number: _____ Fax number: _____

Email address: _____

Office hours:

Monday	_____ a.m.	_____ p.m.
Tuesday	_____ a.m.	_____ p.m.
Wednesday	_____ a.m.	_____ p.m.
Thursday	_____ a.m.	_____ p.m.
Friday	_____ a.m.	_____ p.m.
Saturday	_____ a.m.	_____ p.m.
Sunday	_____ a.m.	_____ p.m.

Accepting new patients? ☐ Yes ☐ No

Age range of patients served:

☐ Pediatric ☐ Geriatric

☐ All ages ☐ Other: _____

Languages spoken_____

Wheelchair accessible? ☐ Yes ☐ No

Office location or remittance address

Do you want to remove an office location? ☐ Yes Do you want to remove a billing/remittance address? ☐ Yes

Site address: _____

Site city, state and zip + 4: _____

Office manager: _____

Phone number: _____ Fax number: _____

To add or remove additional office locations, attach a separate sheet.

Signature: _____

Printed name: _____

Contact phone number: _____

For office use only

Date completed: _____

Date received by Amerigroup: _____