Practice Profile Update Form

To update your practice profile, fax new information using the form below to the Provider Relations department at 757-963-0595. 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 _____

Gender: ☐ Female ☐ Male

Specialty _____

License number _____

NPI _____

WHAT TYPE OF INFORMATION ARE YOU UPDATING?

Please check all that apply.

☐ Billing information

☐ Location or contact information

☐ Office hours

☐ Practice details

☐ Primary care provider 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

Primary care providers are REQUIRED to have coverage 24 hours a day, 7 days a week. Please mark your coverage type below.

☐ Answering service ☐ Beeper or pager ☐ Answering machine

☐ Other phone number _____

Are you accepting new patients? ☐ Yes ☐ No

If yes, please explain: _____

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BILLING INFORMATION

*Please attach a copy of the current W-9 form for all billing information changes.

New tax ID number? ☐ Yes ☐ No

Tax ID number _____
Billing address _____
Phone number _____
Fax number _____
Contact person _____

NEW OR AN ADDITIONAL OFFICE LOCATIONS

☐ New location ☐ Additional location

Site name _____
Site address _____
Office manager _____
Phone number _____
Fax number _____

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

REMOVE AN OFFICE LOCATION

Do you want to remove an office location? ☐ Yes ☐ NoSite name

_____

Site address _____
Office manager _____
Phone number _____
Fax number _____

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

Signature _____
Printed name _____
Contact phone number _____

Contact phone number_____

Date completed _____
Date received by Amerigroup _____

For Office Use Only