Amerigroup RealSolutions in healthcare

https://providers.amerigroup.com

Provider Demographics Address Change Form

Date of request: ____/____/____ Provider ID: _____

Does this request affect one or more of the following? (Check all impacted by updated demographics)

☐ Practitioner ☐ Group ☐ Facility/ancillary (credentialing may be required for new service location)
☐ All practitioners in the group/facility (attach a list of all participating practitioners in group)

Provider name: _____ Tax ID: _____
NPI (practitioner*): _____
NPI (group/facility): _____
* If more than one practitioner needs to be updated, please attach a separate sheet and list name(s)/NPI.

Primary address (If additional locations, list on separate sheet)
New address: _____
City, state, ZIP code: _____
Phone: _____ Fax: _____ Email: _____
Old address: _____
City, state, ZIP code: _____
Phone: _____ Fax: _____ Email: _____

Remit address (*W-9* is required with new address for tax information and *1099*.)
New address: _____
City, state, ZIP code: _____
Phone: _____ Fax: _____ Email: _____
Old address: _____
City, state, ZIP code: _____
Phone: _____ Email: _____

Medical records address
New address: _____
City, state, ZIP code: _____
Phone: _____ Fax: _____ Email: _____
Old address: _____
City, state, ZIP code: _____
Phone: _____ Email: _____

Credentialing contact address
New address: _____
City, state, ZIP code: _____
Phone: _____ Fax: _____ Email: _____
Old address: _____
City, state, ZIP code: _____
Phone: _____ Email: _____

Authorized provider/representative signature: _____
Print name: _____
Title: _____ Phone: _____

This form must be signed and include a contact's name and phone number before it can be submitted for update. Please return the form to Amerigroup Community Care by email (TNnwksup@amerigroup.com) or fax (1-877-423-9973).