CareSource Provider/Group – Hierarchy Change Request Form

Date: _____ PR Rep: _____	☐ Adding a Provider (Adding provider to a participating group) ☐ Deleting a Provider (Deleting a provider from a participating group) ☐ Changing Demographics (Ex. Practice location change, specialty change, NPI/Phone/Fax Change, Capacity, Restrictions) ☐ IRS Name Change ***Details regarding any of the above changes can be placed in NOTES section on the last page***
Group IRS Name (Must Match Line 1 (one) on W-9)	
Group DBA	
Group TIN	
Group NPI	
Group Medicare # (If Applicable)	
Group Medicaid # NOTE- A Valid Medicaid # is REQUIRED for any Medicaid Product and/or MyCare-OH	
Product:	☐ Medicaid - OH ☐ Medicaid – GA ☐ HIP– IN ☐ HHW– IN ☐ MedicareAdv - OH, GA, IN, KY ☐ DSNP-OH, GA, IN, KY ☐ Marketplace – IN ☐ Marketplace - KY ☐ Marketplace – WV ☐ Marketplace - OH ☐ Marketplace - GA ☐ MyCare - OH
Provider Group Website (if applicable)	
Office Contact	
Contact Name	
Contact Phone	
Contact Email	
Please indicate if you are:	☐ FQHC ☐ RHC ☐ QFPP ☐ CMHC ☐ Substance Use Disorder(SUD)/Opioid Use Disorder (OUD) ☐ Opioid Treatment 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**		

Provider	**Deg.**	**Telemedicine Services Provided? (Y/N)**	**Telemedicine Presentation Site? (Y/N)**	**Additional Languages**

Address	**City/County**	**State**	**Zip**

Phone	**Fax**	**NPI #**	**CAQH#**	**Medicaid/IHCP #**	**Medicare #**

Specialty	**Board Certified? (Please Specify Boards)**	**PCP? Y/N**	**If PCP, List Capacity**	**Cultural Compentency (Y/N)**	**Compentency Training Name**

Age Restrictions? (18 yrs & older)	**Race/Ethnicity**	**Gender Restrictions**	**Office Hours**						
			Mon	Tues	Wed	Thur	Fri	Sat	Sun

☐ Adding a Provider (Adding provider to a participating group)

☐ Deleting a Provider (Deleting a provider from a participating group)

Provider #1	**Deg.**	**Telemedicine Services Provided? (Y/N)**	**Telemedicine Presentation Site? (Y/N)**	**Additional Languages**

Address	**City/County**	**State**	**Zip**

Phone	**Fax**	**NPI #**	**CAQH#**	**Medicaid/IHCP #**	**Medicare #**

Specialty	**Board Certified? (Please Specify Boards)**	**PCP? Y/N**	**If PCP, List Capacity**	**Cultural Compentency (Y/N)**	**Compentency Training Name**

Age Restrictions? (18 yrs & older)	**Race/Ethnicity**	**Gender Restrictions**	**Office Hours**						
			Mon	Tues	Wed	Thur	Fri	Sat	Sun

☐ Adding a Provider (Adding provider to a participating group)

☐ Deleting a Provider (Deleting a provider from a participating group)

Provider #2	Deg.	Telemedicine Services Provided? (Y/N)	Telemedicine Presentation Site? (Y/N)	Additional Languages

Address	City/County	State	Zip

Phone	Fax	NPI #	CAQH#	Medicaid/IHCP #	Medicare #

Specialty	Board Certified? (Please Specify Boards)	PCP? Y/N	If PCP, List Capacity	Cultural Compentency (Y/N)	Compentency Training Name

Age Restrictions? (18 yrs & older)	Race/Ethnicity	Gender Restrictions	Office Hours						
			Mon	Tues	Wed	Thur	Fri	Sat	Sun

☐ Adding a Provider (Adding provider to a participating group)

☐ Deleting a Provider (Deleting a provider from a participating group)

Provider #3	Deg.	Telemedicine Services Provided? (Y/N)	Telemedicine Presentation Site? (Y/N)	Additional Languages

Address	City/County	State	Zip

Phone	Fax	NPI #	CAQH#	Medicaid/IHCP #	Medicare #

Specialty	Board Certified? (Please Specify Boards)	PCP? Y/N	If PCP, List Capacity	Cultural Compentency (Y/N)	Compentency Training Name

Age Restrictions? (18 yrs & older)	Race/Ethnicity	Gender Restrictions	Office Hours						
			Mon	Tues	Wed	Thur	Fri	Sat	Sun

☐ Adding a Provider (Adding provider to a participating group)

☐ Deleting a Provider (Deleting a provider from a participating group)

***** Race/Ethnicity = Asian, Black or African American. Hispanic or Latino, American Indian, White, Other, Choose Not to Answer**

Notes:	

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.