



# PROVIDER INFORMATION CHANGE FORM

## Section 1: Provider Designation

Provider Name: \_\_\_\_\_ Participating as:  HIV PCP  PCP  Specialist  Covering

Primary Specialty: \_\_\_\_\_ Secondary Specialty: \_\_\_\_\_ Provider Number: \_\_\_\_\_

Name of Office Contact: \_\_\_\_\_ Title: \_\_\_\_\_

Name/Title of person completing this form (if different than contact): \_\_\_\_\_

## Section 2: Provider Office & Billing Information Verification

Effective Date of Change(s): \_\_\_\_/\_\_\_\_/\_\_\_\_ Request:  New  Change/Correction  Separation Notice  
*(Note: All effective dates are determined by your contractual obligation, please refer to your Amida Care Provider Agreement.)*

Facility/Group Office Name: \_\_\_\_\_

	OLD	NEW
Street Address:	_____	_____
City, State, Zip:	_____	_____
Telephone #:	_____	_____
Fax #:	_____	_____
Billing Address:	_____	_____
Tax ID #:	_____	_____

*If Tax ID change reported, please supply W9.*

## Section 3: Additional Provider Information

Provider Office Hours: Mon.\_\_\_\_ Tues.\_\_\_\_ Wed.\_\_\_\_ Thurs.\_\_\_\_ Fri.\_\_\_\_ Sat.\_\_\_\_ Sun\_\_\_\_  
*(The PCPs must maintain a minimum of 16 hours per office site. Please indicate by the specify actual hours the provider is available to see members. For example: Mon. 12-4p)*

Hospital Affiliation(s): \_\_\_\_\_

Panel Open/Closed: \_\_\_\_\_ Wheel Chair Accessible (circle): Yes No

***Attached separate document(s) to note additional comments***

## Section 4: Office Attestation

Office Contact Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**For Amida Care Office Use:**  Received via Telephone  Received via Fax/Mail  Received via Email

*Amida Care Representative:* \_\_\_\_\_ *Date Received:* \_\_\_\_/\_\_\_\_/\_\_\_\_

*Amida Care Representative:* \_\_\_\_\_ *RHC Updated:* \_\_\_\_/\_\_\_\_/\_\_\_\_