Amerigroup
District of Columbia

https://providers.amerigroup.com/DC

# *Practice Profile Update Form*

To update your practice profile, fax or email new information using the form below to the Provider Relations department at **1-855-875-3629** or dcproviderdata@amerigroup.com. 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: | Specialty: | |
| License number: | NPI: | |
| Provider email: | | Gender: ☐ Female ☐ Male |
| Practice website: | | |

**What type of information are you updating?**

**Please check all that apply.**

☐ Practice details
☐ Primary care provider details
☐ Provider email
☐ Practice website
☐ Billing information
☐ New or an additional office location
☐ Remove an office location
☐ Other: ______________________________________

**Practice details**

| Office hours: | From: | To: |
|---|---|---|
| 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 no, please explain: ______________________________________________________________________________

| **Billing information**<br>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: | | |
| Contact person: | | |
| City: | State: | Zip: |
| Phone number: | Fax number: | |
| **New or an additional office location** | | |
| ☐ New location ☐ Additional location | | |
| Site name: | | |
| Site address: | | |
| City: | State: | Zip: |
| Office Manager: | | |
| Phone number: | Fax number: | |

| Office hours: | From: | To: | Age range of patients served: |
|---|---|---|---|
| Monday | _________ a.m. | ________ p.m. | ☐ Pediatric ☐ Geriatric |
| Tuesday | _________ a.m. | ________ p.m. | ☐ All ages ☐ Other: ____________________________ |
| Wednesday | _________ a.m. | ________ p.m. | |
| Thursday | _________ a.m. | ________ p.m. | Languages spoken: _____________________________________________ |
| Friday | _________ a.m. | ________ p.m. | |
| Saturday | _________ a.m. | ________ p.m. | Wheelchair accessible? ☐ Yes ☐ No |
| Sunday | _________ a.m. | ________ p.m. | |

| **Remove an office location** | | |
|---|---|---|
| Site name: | | |
| Site address: | | |
| City: | State: | Zip: |
| Office Manager: | | |
| Phone number: | Fax number: | |
| **To add or remove additional office locations, attach a separate sheet.** | | |

**Please sign and date**

Signature: ________________________________________________ Printed name: __________________________________

Contact phone number: ___________________________________ Date completed: _____________________

*For office use only*

Date received by Amerigroup District of Columbia, Inc.: _____________________