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Washington Apple Health and Foundational Community Supports Practice Profile Update Form

To update your practice profile, fax new information using the form below to the Provider Data Management department at 757-963-0595. If you have any questions or need assistance, please contact your Washington Provider Relations representative or call 1-800-454-3730. For Foundational Community Supports (FCS), contact your FCS manager at 1-844-451-2828.

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 <u>required</u> 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: ____

FCS providers are required to have coverage with the same availability as for other clients.

Are you accepting new patients/enrollees? ☐ Yes ☐ No

If yes, please explain: ____
____

* Does not apply to FCS.

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 location

□ 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/enrollees?
□ 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 □ No
Site 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: ____________________________________

Date completed: ____________________________________

Date received by Amerigroup Washington, Inc.:
____

For office use only