Provider Update Form

amplifon Hearing Health Care

Instructions

This form is for businesses currently contracted with Amplifon Hearing Health Care. Complete this form if you have a NEW hire and need to add them to an existing clinic location, update information on a current provider (including treating locations), or to TERMINATE a provider from your Amplifon contract.

Identify the Business *(Required)*

Business Name (Legal)	
Business Street Address	City, State & Zip Code
Business Phone	EIN / Tax ID Number

Identify the Provider *(Required)*

Provider First Name	Provider Middle Name	Provider Last Name
AUD / HAD	License #	State of Issue
CAQH ID #	NPI #	

What Do You Want To Do? *(Please select only ONE option per form)*

☐ **NEW Hire / Request to Add as NEW Provider**

All providers must be individually credentialed by Amplifon Hearing Health Care. **A credentialing application will be sent to the provider at the email provided below**. Upon receipt of a completed application, Amplifon will notify the business and the provider of the credentialing decision. ***Please note that the provider is not active under your Amplifon contract until their credentialing is complete and approved***.

Provider's *Primary* Location - Street Address			City, State & Zip Code
Currently Practicing at this Location?	Yes	No	If NO, what is their expected start date?
Provider Email			

☐ **Update Current Provider's Information** Effective Date

Provider Demographic Changes:	
Update Name To: (First, MI, Last)	Reason for Change
Update Provider Email	

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Provider Location / Clinic Changes: (If you are adding the provider to a location that is not already part of AHHC network, please complete a Business Update Form.)	
Please indicate if you are REMOVING or ADDING the listed location to the provider named above:	
Remove Location from Provider	***Add*** Location to Provider
Location Street Address	City, State & Zip Code
Remove Location from Provider	***Add*** Location to Provider
Location Street Address	City, State & Zip Code
Remove Location from Provider	***Add*** Location to Provider
Location Street Address	City, State & Zip Code

☐ **TERIMINATE Provider** Effective Date

**** This will terminate the provider from your AHHC Network Participation Agreement at all locations.*

*** Must be signed by the business owner or authorized contact.

Signature *Signature of the Person Submitting this Form*

Name *Name of the Person Submitting this Form (print)*

Date of Signature

How to submit the Provider Update Form:

E-mail: Credentialing@amplifon.com (preferred), or by ***Fax:*** (877) 853-3010

Questions? Contact a Credentialing representative by Phone: 1-800-862-9381