Amendment Request Form

Please complete this form and email it to amendment_request@carelon.com

Organization's Name:	
Date of Request:	
Provider ID#:	
Tax Identification Number (TIN):	
NPI:	
Practice Address - Street:	
Practice Address - City:	
Practice Address - State:	
Contact Name:	
Contact Email:	
Contact Phone number:	

*Separate form needs to be submitted for each practice state

Request Type

(Select one or more that apply):

- ☐ New service request
- ☐ Code addition/modification
- ☐ Rate review
- ☐ Line of Business

Please complete the relevant sections below according to your request type.

New Service Request or Code Addition / Modification

Service/Procedure Details

CPT/HCPCS Code(s): Include all relevant procedure codes	
Description of the service or procedure	
Modifiers (if any)	

Additional Information

Rate Review

Current vs. Requested Rate Information

Procedure Code	Current Rate	Requested Rate	Justification
CPT 90834	$XX.XX	$YY.YY	Increased cost of service, benchmarking, etc.

Line of Business

Line of Business	Current	Add	Remove
Medicare	☐	☐	☐
Medicaid	☐	☐	☐
Commercial	☐	☐	☐
EAP	☐	☐	☐

Medicare ID:

Medicaid ID:

Reason for Request	[Brief explanation of why the LOB is being added or removed, e.g., "Expansion of services," "No longer serving population," etc.]

Supporting Documents

Select all that apply	☐ W-9 ☐ Licensure/Certification (if applicable) ☐ Accreditation (if applicable) ☐ Other (specify)

Additional Information

Signature

Provider/Representative Name	
Title	
Date	

All requests will be forwarded to the Contracting Department for review.