

Provider Contract Inquiry Form

Date:		
Completed form should be returned to:		
Name:	Email:	
Return to your Account Executive or ProviderRecruitmentTexas@amerihealthcaritas.com .		
Specialty:		
<input type="checkbox"/> Primary care provider (PCP)	<input type="checkbox"/> Behavioral health	<input type="checkbox"/> Long Term Services and Supports
<input type="checkbox"/> Specialist	<input type="checkbox"/> Hospital	<input type="checkbox"/> Vision
<input type="checkbox"/> Ancillary	<input type="checkbox"/> Dental	<input type="checkbox"/> Other

Group or provider information	
Legal entity name (W9):	
Tax ID number (TIN):	Group NPI:
CAQH number:	Medicaid number:
Legal entity signatory:	
Legal entity signatory title:	Medicare number:

Notice correspondence information
Legal notice mailing address including contact name:

Contact information for contract processing	
Contact name:	Title:
Mailing address:	
<input type="checkbox"/> Check if primary address is the same as mailing address	
Contact phone:	Contact email:

Assignment of payment	
Compensation payable by AmeriHealth Caritas Texas is payable to the TIN and address above. <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no , payment is to be assigned to:	
Name:	TIN:
Address:	