AmeriHealth Caritas Florida

Request to Contract Form

☐ **Medicaid**

***Provider type:**
☐ **PCP** ☐ **Specialist** ☐ **Hospitalist** ☐ **FQHC** ☐ **RHC**

*Is your organization (and all providers) currently enrolled in Medicaid? ☐ Yes ☐ No	*Group Medicaid ID #:
*Legal/W-9 name:	
*Practice/DBA name:	

***Provider information**

Please complete the section below with all providers who wish to participate. Every provider who wishes to participate must be included with full information.
☐ Check here if your list of providers exceeds the format below. An Account Executive will contact you for their additional information.

*Provider name:	*NPI	*Primary specialty: Secondary specialty:	*Provider Medicaid ID#
Provider name:	NPI	Primary specialty: Secondary specialty:	Provider Medicaid ID#
Provider name:	NPI	Primary specialty: Secondary specialty:	Provider Medicaid ID#
Provider name:	NPI	Primary specialty: Secondary specialty:	Provider Medicaid ID#
Provider name:	NPI	Primary specialty: Secondary specialty:	Provider Medicaid ID#
Provider name:	NPI	Primary specialty: Secondary specialty:	Provider Medicaid ID#
Provider name:	NPI	Primary specialty: Secondary specialty:	Provider Medicaid ID#

Primary location

☐ **Secondary location** (Please check this box if you have a secondary location. You will be contacted for full information.)

*Address:	
*Phone number:	Fax number:
*Email:	
*Do you want to be listed in the provider directory? ☐ Yes ☐ No	
*Office hours: Mon: Tues: Wed: Thurs: Fri: Sat/Sun:	
*Accepting new patients: ☐ Yes ☐ No	*Patient ages seen:
***Practice data** Patient-centered medical home: ☐ Yes ☐ No	

Important billing numbers

*Group NPI:
*Group Taxpayer Identification Number (TIN):

Requestor contact information

*Requestor name:	
*Requestor number:	*Requestor fax number:
*Requestor email address:	

*Required.

To submit this completed Request to Contract Form, please e-mail it to **PNM_inquiries@amerihealthcaritasfl.com.**

www.amerihealthcaritasfl.com