AmeriHealth Caritas North Carolina

FAMILY OF HEALTH PLANS

# Provider Contract/ Amendment Inquiry Form

Currently participating in the AmeriHealth Caritas North Carolina (Medicaid) network ☐

Please select all plans you would like to join:
☐ AmeriHealth Caritas North Carolina (Medicaid) plan
☐ AmeriHealth Caritas Next (individual and family health plans both on and off the Exchange [ACA])

Date:

**Completed form and W-9 should be returned to your Account Executive or ProviderRecruitmentNext@amerihealthcaritas.com.**

**Specialty:**

☐ Primary care provider (PCP)
☐ Specialist
Specialty:
☐ Ancillary
☐ Behavioral health
☐ Hospital
☐ Dental
☐ Vision
☐ Long-term care/Home- and community-based services
☐ Other

## Group or provider information

| | |
|---|---|
| Legal entity name (W-9): | |
| Tax ID number (TIN): | Group NPI: |
| CAQH number (if applicable): | Medicaid number: |
| Legal entity signatory: | Medicare/CCN number: |
| Legal entity signatory title: | |

## Notice correspondence information

Legal notice mailing address, including contact name:

## Contact information for contract processing

| | | |
|---|---|---|
| Contact name: | Title: | |
| Primary address: | | |
| Fax: | Taxonomy code: | |
| Mailing address: | | County: |
| ☐ Check if primary address is the same as the mailing address. | | |
| Contact telephone: | Contact email: | |