AmeriHealth Caritas Florida

FAMILY OF HEALTH PLANS

Provider Contract/ Admendment Inquiry Form

Please select all plans you would like to join:
- ☐ AmeriHealth Caritas Next (Individual and family health plans offered on and off the Exchange [ACA])
- ☐ AmeriHealth Caritas VIP Care (Medicare Advantage dual-eligible special needs plan [D-SNP])
- ☐ All

Date:

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

Specialty:

☐ Primary care provider (PCP)	☐ Ancillary	☐ Dental
☐ Specialist	☐ Behavioral health	☐ Vision
Specialty:	☐ Hospital	☐ Other

Group or provider information

Legal entity name (W9):	
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 mailing address		
Contact telephone:	Contact email:	