AmeriHealth Caritas California

Provider Contract Inquiry Form

Date:
Completed form should be returned to: Name: Email: Return to your Account Executive or **ProviderRecruitmentCA@amerihealthcaritas.com**.
Specialty: ☐ Primary care provider (PCP) ☐ Behavioral health ☐ Vision ☐ Specialist ☐ Hospital ☐ Other ☐ Ancillary ☐ Dental

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

Notice correspondence information
Legal notice mailing address including contact name:

Contact information for contract processing	
Contact name:	
Title:	
Mailing address:	
☐ Check if primary address is the same as mailing address	
Contact telephone:	
Contact email:	