AmeriHealth Caritas Delaware

FAMILY OF HEALTH PLANS

Provider Contract/ Amendment Inquiry Form

Currently participating in the AmeriHealth Caritas Delaware Medicaid network ☐

Please select all plans you would like to join:

☐ All
☐ Medicare Advantage dual-eligible special needs plan (D-SNP)
☐ AmeriHealth Caritas Delaware Medicaid plan
☐ Individual and family health plans both on and off the exchange (ACA plans)

Date:

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

Specialty:

☐ Primary care provider (PCP)
☐ Specialist
☐ 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:	
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:	
☐ Check if primary address is the same as mailing address	
Contact telephone:	Contact email: