AmeriHealth Caritas Ohio

Provider Contract Inquiry Form

www.amerihealthcaritasoh.com

Date:
Return completed form to your Account Executive or **providerrecruitmentoh@amerihealthcaritas.com.**

Specialty:

☐ Primary care provider (PCP)	☐ Hospital	☐ Other (specify)
☐ Specialist	☐ Dental	
☐ Ancillary	☐ Vision	
☐ Behavioral health	☐ Home health	

Group or provider information (Insert page with each provider's name, Medicaid ID, and NPI.)	
Legal entity name (W9):	
Tax ID number (TIN):	Group NPI:
Group Medicare number:	Group Medicaid number:
Print legal entity signatory name:	
Legal entity signatory title:	
Legal entity signatory email:	

Contact information for contract processing	
Contact name:	Contact title:
Contact telephone:	Contact email:

Address information
Legal notice address, including contact name:
Mailing address:
Location address (include county):
☐ Check if primary address is the same as location address.

Assignment of payment	
Compensation payable by AmeriHealth Caritas Ohio, Inc. is payable to the TIN and address above. ☐ Yes ☐ No	
If **no**, payment is to be assigned to:	
Name:	TIN:
Address:	