AmeriHealth Caritas Ohio

Provider Contract Inquiry Form

Date:
Completed form should be returned to: Name: Email: Return to your Account Executive or **providerrecruitmentoh@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:
CAQH number:	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:
Mailing address:	
☐ Check if primary address is the same as mailing address	
Contact telephone:	Contact email:

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:	