

Date:		
<b>Completed form should be returned to:</b>		
Name:	Email:	
Return to your Account Executive or <a href="mailto:providerrecruitmentwv@amerihealthcaritas.com">providerrecruitmentwv@amerihealthcaritas.com</a> .		
<b>Specialty:</b>		
<input type="checkbox"/> Primary care provider (PCP)	<input type="checkbox"/> Behavioral health	<input type="checkbox"/> Vision
<input type="checkbox"/> Specialist	<input type="checkbox"/> Hospital	<input type="checkbox"/> Other
<input type="checkbox"/> Ancillary	<input type="checkbox"/> 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:	
<input type="checkbox"/> Check if primary address is the same as mailing address	
Contact telephone:	Contact email:

Assignment of payment	
Compensation payable by AmeriHealth Caritas West Virginia, Inc. is payable to the TIN and address above. <input type="checkbox"/> Yes <input type="checkbox"/> No	
If <b>no</b> , payment is to be assigned to:	
Name:	TIN:
Address:	