AmeriHealth Caritas
Delaware

Provider Data Intake Form

Please email completed form to
delawareprovidernetwork@amerihealthcaritas.com
or fax it to **1-877-759-6251**.

Date completed: _____

Practice information			
Entity name:		Doing business as (DBA) name, if applicable:	
Provider group TIN:		Provider group NPI:	
Primary contact name:	Primary contact phone:	Primary contact fax:	Primary contact email:

Practice locations								
	Street address	City	State	ZIP	Phone	Fax	Office hours	Handicap accessible
Location 1								☐ Yes ☐ No
Location 2								☐ Yes ☐ No
Location 3								☐ Yes ☐ No

Billing information			
Group pay to address:	City:	State:	ZIP:

Supplemental provider information										
Provider name	Degree	Specialty	CAQH number (required)	Provider NPI	Taxonomy number	Number of locations (from above)	Languages spoken by provider and/or office staff	Hospital affiliation	Board certification	Accepting new patients
									☐ Yes ☐ No	☐ Yes ☐ No
									☐ Yes ☐ No	☐ Yes ☐ No
									☐ Yes ☐ No	☐ Yes ☐ No
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									☐ Yes ☐ No	☐ Yes ☐ No
									☐ Yes ☐ No	☐ Yes ☐ No
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