AmeriHealth Caritas Delaware

Provider Data Intake Form

Instructions:

- Prior to returning all fields must be completed in its entirety for each Practitioner listed.
- A copy of the W9 must be submitted per tax entity.
- Medicaid ID and DMMA approval letter must be included (Each practitioner is required to have a Medicaid ID per location)
- Access should also be granted to CAQH for AmeriHealth Caritas Delaware to be able to access and review your information. (CAQH ID 9CAQH application must include all information noted below):

✓ Proof of completed education in the requested Specialty Evidence of professional liability insurance

✓ Current State Medical License(s) — must be current, active, unrestricted Licensure

✓ Current DEA Registration Certificate(s) (if applicable) — must be current, active, unrestricted Licensure

✓ Current CDS/CSR Certificate(s) (if applicable) — must be current, active, unrestricted Licensure

✓ Ownership Disclosure form must be submitted at time of application.

✓ Hospital privileges-if no hospital privileges, admitting arrangements must be provided instead.

✓ Admitting Arrangement/Collaborative Agreement required for mid-level providers (NP/PA) and practitioners who do not have admitting privileges.

✓ Board Certification

✓ Professional Certification(s) (if applicable) for Midlevel Practitioners

✓ ECFMG# Certificate (if applicable)

✓ Individual NPI Number

✓ Individual Medicaid Number

✓ Individual Medicare Number, if applicable

✓ Ownership Disclosure

✓ Evidence of the practitioners past five years of professional liability claims history

✓ CV (Resume) Past five years of work history with no gaps greater than six months

✓ CLIA # (if applicable)

✓ Explanation for any affirmative responses to the Disclosure Questions on the application

If you have more than six locations, please attach a roster with the same fields listed on this document.

AmeriHealth Caritas Delaware

Provider Data Intake Form

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

Section 1 instructions: Please complete all fields below for the provider.

Entity name (as written on W9):	Provider type: ☐ PCP ☐ Specialist ☐ Behavioral health ☐ Urgent care ☐ FQHC ☐ RHC		
Independent practice association (IPA) name (if applicable):	Billing type: ☐ UB-04/institutional ☐ CMS 1500/professional		
Name doing business as (if applicable):	Group or facility TIN/EIN (nine characters):		
Primary contact name:			
Primary contact email:	Primary contact phone:		
Hospital admitting privileges:	Hospital affiliations:		
Pay to (street address):	Building or suite number:	City, state, ZIP:	
Recoveries address (if different from **Pay to** above):	Building or suite number:	City, state, ZIP:	
Provider office hours:			
Credentialing contact name:	Credentialing contact phone:	Credentialing contact email:	
Credentialing contact physical address (if different from main office location):			
Organization website:	Cultural competency completion: ☐ Yes ☐ No		

Section 2 instructions: Please complete each section below for all locations, including applicable NPI and Medicaid ID information. (Make additional copies if needed.)

Location	**Group name** (as it should appear in a provider directory)	**Street address**	**Building or suite number**	**City**	**State**	**ZIP code + 4**	**County**	**Taxonomy code**	**CLIA number**	**Group or facility NPI, Medicaid ID, and CLIA number**	**Phone with area code**
Main practice location 1										NPI Medicaid	
Practice location 2										NPI Medicaid	
Practice location 3										NPI Medicaid	
Practice location 4										NPI Medicaid	

Please feel free to attach an additional document if more space is required.

Section 3 instructions: Please enter the office hours for each location..

Practice location — office hours								
Day	**No set hours**				**Start time to end time (include a.m. and p.m.)**			
	Location 1	**Location 2**	**Location 3**	**Location 4**	**Location 1**	**Location 2**	**Location 3**	**Location 4**
Monday	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours				
Tuesday	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours				
Wednesday	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours				
Thursday	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours				
Friday	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours				
Saturday	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours				
Sunday	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours	☐ Closed ☐ Open ☐ 24 hours				

Section 4 instructions: Please indicate ADA compliance for each location, as appropriate.

ADA compliance	Group locations
Blind/visually impaired (ADA5)	☐ All ☐ 1 ☐ 2 ☐ 3 ☐ 4
Cognitively disabled (ADA6)	☐ All ☐ 1 ☐ 2 ☐ 3 ☐ 4
Deaf or hard of hearing (ADA7)	☐ All ☐ 1 ☐ 2 ☐ 3 ☐ 4
Examination rooms — compliant access (ADA3)	☐ All ☐ 1 ☐ 2 ☐ 3 ☐ 4

ADA compliance	Group locations
Handicap-accessible medical equipment (ADA4)	☐ All ☐ 1 ☐ 2 ☐ 3 ☐ 4
Restrooms — compliant access (ADA2)	☐ All ☐ 1 ☐ 2 ☐ 3 ☐ 4
Service location — compliant access (ADA1)	☐ All ☐ 1 ☐ 2 ☐ 3 ☐ 4

Date: ____________________________

Instructions: Please complete all fields below for each practitioner. If you have more than 10 practitioners, please attach a roster with the same fields listed in this section.

Location number for practitioner	First name	Last name	MI	Gender	Hospital Affiliated with admitting privileges
				☐ Female ☐ Male	

Specialty	Age range	Accepting new patients?	Taxonomy code	Practitioner Medicaid ID	Practitioner NPI	CAQH registration number	Category
	From age _____ to age _____ ☐ All ages	☐ Yes ☐ No					☐ PCP ☐ Specialist ☐ Behavioral health ☐ Allied ☐ Other

Languages spoken (please list)	Provider training/experience: CLAS Standards and other (please list):

Location number for practitioner	First name	Last name	MI	Gender	Hospital Affiliated with admitting privileges
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Languages spoken (please list)	Provider training/experience: CLAS Standards and other (please list):

Would you like to be included in the directory? ☐ Yes ☐ No

Date: _____

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Languages spoken (please list)	Provider training/experience: CLAS Standards and other (please list):

Would you like to be included in the directory? ☐ Yes ☐ No

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Languages spoken (please list)	Provider training/experience: CLAS Standards and other (please list):

*Panel must be closed or all payers to close panel for AmeriHealth Caritas Delaware.

Would you like to be included in the directory? ☐ Yes ☐ No