AmeriHealth
DISTRICT OF COLUMBIA

PRACTITIONER INFORMATION FORM

Internal Use Only Network Need: ☐ Yes ☐ No

Please Print ☐ Update ☐ New

Today's Date:	☐ PCP ☐ Specialist	☐ Open Panel ☐ Closed Panel	Max Panel Size:

PRACTITIONER INFORMATION

Practitioner's Last Name:	First:	Middle:
Board Certified: ☐ Yes ☐ No	☐ MD ☐ DO ☐ DPM ☐ DDS ☐ DMD	Birth Date:
Specialty: *(Services for which you have a license to perform)*		
Scope of Services:		
Board Speciality:	Taxonomy Code:	

PRACTICE INFORMATION

Group Name:			Web site:			
See New Patients: ☐ Yes ☐ No	Ages Seen:	Office Manager:				
Practive Address:					Suite #:	
City:			State:		Zip+4:	
Phone:			Fax:			
Email:			Cell:			
Office Hours:	Mon:	Tue:	Wed:	Thur:	Fri:	Sat:

BILLING INFORMATION

Billing Address:		Suite #:
City:	State:	Zip+4:
Phone:	Fax:	
Name On Check:	Tax ID:	
Group NPI:	Individual NPI:	
Medicaid #:	Medicare #:	

CAQH DATA

Do you have a CAQH number: ☐ Yes ☐ No	CAQH no.:

**Please attach CAQH Application with your Information Form.
If you do not have a CAQH member ID, one will be provided to you by your Provider Relations Representative. If there are any questions regarding the Practitioner Information form, please contact you Provider Rep.

ADDITIONAL LOCATIONS

Address 1:		Suite #:
City:	State:	Zip+4:
Phone:	Fax:	
Address 2:		Suite #:
City:	State:	Zip+4:
Phone:	Fax:	

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