Provider Contract Inquiry Form

AmeriHealth Caritas Louisiana

Completed form should be returned to Provider Network Management at: **network@amerihealthcaritasla.com**

Specialty:				
☐ Primary care provider (PCP)	☐ Ancillary	☐ Behavioral health	☐ Specialist	☐ Hospital

Group or provider information	
Legal entity name (W9):	
Tax ID number (TIN):	Group NPI:
Address:	
City, state:	ZIP code:
Medicaid number:	
Provider name:	
Provider NPI:	
CAQH number:	
Legal entity signatory name and title:	
Legal entity signatory email:	

Notice correspondence information
Legal notice mailing address, including contact name:

Contact information for contract processing	
Contact name:	
Title:	
Mailing address:	
City, state:	ZIP code:
Contact telephone:	
Contact email:	

To be completed by AmeriHealth Caritas Corporate Account Executive (for internal use only):

Assigned Account Executive:
Date contract sent: