AmeriHealth Caritas
District of Columbia

Provider Data Intake Form

Note to all providers:

To finalize the credentialing process, you must complete four online provider orientation modules located on our website at **www.amerihealthcaritasdc.com/provider/resources/training.aspx**. At the end of each module, there is a form you must complete attesting to the fact that you finished the module. Provider credentials from this form must match the information used to complete the attestation form.

Primary care providers (PCPs) treating members under age 21 must also complete the District's HealthCheck Training Module before the credentialing process can be completed. The HealthCheck training module can be found at **www.dchealthcheck.net**.

Internal use only Network need: ☐ Yes ☐ No ☐ Medicaid ☐ Alliance

Please type or print.

Today's date:	Provider type: ☐ PCP ☐ Specialist ☐ Ancillary ☐ Facility
Include in directory: ☐ Yes ☐ No	☐ Open panel ☐ Closed panel Maximum panel size:

Practitioner/clinician information

Last name:	First:	Middle:
Board certified: ☐ Yes ☐ No	License:	Birthdate:
Board specialty (services you have a license to perform):		
Provider's languages:		

Race*:

☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White
☐ Asian
☐ American Indian or Alaska Native
☐ Middle Eastern or North African
☐ Some other race
Please specify:

Ethnicity*:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Are you affiliated with one of the following:

☐ Indian tribe (I) ☐ Urban Indian Organization (U) ☐ Tribal organization (T) ☐ Not applicable

Type of services:	Taxonomy code:

* This information will be used upon request by our members to select a culturally and linguistically appropriate provider. It will only be provided to members upon request. It will not be printed in our online or paper directories.

Provider Data Intake Form

Practice information

Group or facility name: (as it will appear in provider directory)			
Website:			
Seeing new patients: ☐ Yes ☐ No	Ages seen:	Office manager:	
Languages spoken by clinical staff at facility:			
Address:			Suite number:
City:	State:		ZIP:
Phone: (The office phone number listed is the primary method for patients to use when scheduling an appointment.)	Fax:		
Email:	Cell:		

Office hours:	Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:

Billing information

Billing address:		Suite number:
City:	State:	ZIP:
Phone:	Fax:	
Legal business name:	Tax ID:	
Group NPI:	Individual NPI:	
Medicaid number:	Medicare number:	

Council for Affordable Quality Healthcare (CAQH) data

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

Additional location

Street address:		Suite number:
City:	State:	ZIP:
Languages spoken by clinical staff at facility:		
Phone:	Fax:	

Office hours:	Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:

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Additional location		
Street address:		Suite number:
City:	State:	ZIP:
Languages spoken by clinical staff at facility:		
Phone:	Fax:	

Office hours:	Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday: