AmeriHealth Caritas
District of Columbia

Provider Data Intake Form

Instructions to all providers:
Kindly ensure this form is **fully completed,** as incomplete submissions may lead to processing delays. Along with your completed intake form, please attach the following documents with your submission to dcprovidernetwork@amerihealthcaritasdc.com.

1) W-9 Form
2) Disclosure of Ownership Form
3) Active Malpractice and Liability Coverage
4) CAQH Attestation required – every 120 days

To finalize the credentialing process, **you must complete the seven online provider orientation modules** located on our website at www.amerihealthcaritasdc.com/provider/resources/training.aspx.

- Provider Orientation Module 1: Intro to AmeriHealth Caritas DC
- Provider Orientation Module 2: Key Departments and Provider Information
- Provider Orientation Module 3: Claims and Payment Process
- Provider Orientation Module 4: Provider Responsibilities
- Provider Orientation Module 5: Care Management Program
- Provider Orientation Module 6: Introduction to Cultural Competence
- LGBTQ cultural competency training

At the end of each module, you are required to complete an attestation form confirming that you have finished the module. **Please attach your completed attestations to your application submission.** The provider credentials listed on this form must match the information provided on each 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.

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:
Individual NPI:	License No:	Birthdate:
Board certified: □ Yes □ No	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.

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:		
Practice 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:	
Medicare Number (PTAN):	Group NPI:	
DC Medicaid number:	DC Medicaid Effective Date:	DC Medicaid End Date:

Council for Affordable Quality Healthcare (CAQH) Data

Do you have a CAQH number: □ Yes □ No	CAQH number:	CAQH Attestation Date:

Additional Location Information:

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

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

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:

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

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance.

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5400ACDC-1322-211
Revised May 2025

www.amerihealthcaritasdc.com