INITIAL CONTRACT REQUEST FORM

****For a new group contract, only one form per group is required. Please do not submit any credentialing information until a Contract Negotiator has sent you a contract for review.****

FAX THIS FORM AND A W-9 TO: 866-480-3227

PLEASE INDICATE YOUR PROVIDER TYPE – Choose all that apply:

☐ Medical Group	☐ Hospital	☐ Ambulance
☐ Solo Practitioner	☐ Hospice or Home Health	☐ Surgical Center
☐ FQHC or RHC	☐PT ☐OT ☐ST	☐Urgent Care Center
☐ DME, O&P, or Home Infusion	☐ Lab or Imaging Center	☐ Hospital-Based Practitioners
☐ Dialysis Center	☐ Skilled Nursing Facility	☐ Other _____

GROUP INFORMATION

Group Name (Including D/B/A Name):		
Primary Physical Address:	**City/State/Zip**	**Phone:**
Administrative Contact Person/Title:	**E-mail:**	**Fax:**
Hours of Operation: **Mon_____Tues_____Wed_____** **Thurs_____Fri_____**	**County:**	**Group Medicaid #:**
Group BILLING National Provider Identifier (NPI)#:	**Group Medicare #:**	**Group TIN #:**
Credentialing Contact Person Name, Phone Number, and E-mail address (if different from above):		
Website URL:		

Does your office meet Americans with Disabilities Act (ADA) requirements for accessibility? ☐ Yes ☐ No
Do your physicians/practitioners speak a language other than English? ☐ Yes ☐ No
If so, what language(s)?
Is language interpretation available in your office? ☐ Yes ☐ No

Choose all that apply: ☐ MSCAN ☐ Ambetter ☐ CHIP ☐ Medicare Advantage

Do you see children in your practice? ☐ Yes ☐ No If yes, what is the age range? _____

Notes: _____