

Contract Application

Please type in each field. Handwritten forms will not be accepted.

Contract type: Select applicable plan(s). <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> CHC <input type="checkbox"/> CHIP				<input type="checkbox"/> W9 attached (signed within last 180 days)	
Provider type: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist — provider type:			<input type="checkbox"/> Ancillary <input type="checkbox"/> Facility		
Legal entity name:*			Group NPI:*		Group TIN:*
Contracting contact name:*			Phone:*	Email:*	
Credentialing contact name:*			Phone:*	Email:*	

Practice locations	Practice name (as it will appear in the directory)		Street address (as it will appear in the directory)		City	ST	ZIP
	Phone	Fax	Group PROMISe ID# **	Group Medicare ID# †	County		
Primary* (all fields required)							
Location #2							
Location #3							
Location #4							
Location #5							
Location #6							
Location #7							
Location #8							
Location #9							

Please email form to: PNMcontracting@amerihealthcaritas.com

* Required

** Enrollment in the PA Medical Assistance Program is required in our Medicaid Product. If you are not enrolled and do not have a PROMISe ID, we cannot credential you for participation. If you need to enroll, please call the Department of Human Services (DHS) at **1-800-537-8862**.

† Enrollment in Medicare is required in our Medicare Product. If you are not enrolled and do not have a Medicare ID, we cannot contract or credential you for participation. If you need to enroll, please complete the online PECOS application through the Centers for Medicare & Medicaid Services (www.cms.gov > Medicare > Enrollment & renewal > Providers & suppliers).



Questions (Please complete ALL questions):

How are you submitting claims?	<input type="checkbox"/> CMS 1500 <input type="checkbox"/> UB04
Do you have valid PROMISe ID #s for your group and all providers at ALL service/office locations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A — Medicare only
How many providers are you looking to credential with our plans?	
Are you billing J codes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you billing adult immunizations/vaccinations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you administering VFC immunizations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Which type(s) of therapy do you provide?	<input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> N/A
Which place(s) of service do you evaluate and treat patients?	<input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> Other:
Do you provide telehealth services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you provide or prescribe DME?	<input type="checkbox"/> Provide <input type="checkbox"/> Prescribe <input type="checkbox"/> N/A
Radiology Services: Do you bill Total Component, Technical Component, Reading Component?	<input type="checkbox"/> Total <input type="checkbox"/> Technical <input type="checkbox"/> Reading <input type="checkbox"/> N/A
Radiology Equipment: If you have such equipment, please provide current certifications for same.	<input type="checkbox"/> Certifications attached <input type="checkbox"/> N/A
Laboratory Services: If you have services above reagent tests, please provide CLIA certification(s).	<input type="checkbox"/> Certifications attached <input type="checkbox"/> N/A
Urgent Care: Are you an Accredited Urgent Care? If so, please provide accreditations.	<input type="checkbox"/> Accreditations attached <input type="checkbox"/> N/A
FQHC/RHC: Please provide the current PPS rate letter for each location.	<input type="checkbox"/> PPS rate letter(s) attached <input type="checkbox"/> N/A
Pediatric Shift Care: Skilled nursing/support for children with complex medical needs in their home or residence?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Addiction Medicine: Are you recognized as a Center of Excellence or do you provide medication-assisted treatment?	<input type="checkbox"/> COE <input type="checkbox"/> MAT <input type="checkbox"/> N/A
Oral Surgery: What do you bill? CPT, CDT, or both?	<input type="checkbox"/> CPT <input type="checkbox"/> CDT <input type="checkbox"/> Both <input type="checkbox"/> N/A

Internal only

# of providers in region:	Adequacy met? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Justification:			
Manager name:	Approved/Denied:	Date:	

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January 2026