

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.amerhealthcaritasdc.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: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Ancillary <input type="checkbox"/> Facility
Include in directory: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open panel <input type="checkbox"/> Closed panel Maximum panel size:

Practitioner/clinician information		
Last name:	First:	Middle:
Board certified: <input type="checkbox"/> Yes <input type="checkbox"/> No	License:	Birthdate:
Board specialty (services you have a license to perform):		
Provider's languages:		
Race*:		
<input type="checkbox"/> Black or African American	<input type="checkbox"/> American Indian or Alaska Native	
<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> Middle Eastern or North African	
<input type="checkbox"/> White	<input type="checkbox"/> Some other race	
<input type="checkbox"/> Asian	Please specify:	
Ethnicity*:		
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		
Are you affiliated with one of the following:		
<input type="checkbox"/> Indian tribe (I) <input type="checkbox"/> Urban Indian Organization (U) <input type="checkbox"/> Tribal organization (T) <input type="checkbox"/> 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:
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