

Date: \_\_\_\_\_

Coverage by AmeriHealth First.

<b>PROVIDER</b>	<b>Provider identification</b>	
	Provider name:	
	<input type="radio"/> AmeriHealth Caritas Pennsylvania <input type="radio"/> AmeriHealth Caritas Northeast	Plan-assigned provider ID number:
Phone number:		

**Providers can submit up to five separate referrals at a time using this form.**

<b>MEMBER</b>	<b>Member identification</b>	
	Member name (first, middle, last):	
	<input type="radio"/> AmeriHealth Caritas Pennsylvania <input type="radio"/> AmeriHealth Caritas Northeast	Member ID number:
	Date of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visit:	
Does the member need assistance locating a dental provider? <input type="radio"/> Yes <input type="radio"/> No		Does the member need assistance making an appointment? <input type="radio"/> Yes <input type="radio"/> No

<b>MEMBER</b>	<b>Member identification</b>	
	Member name (first, middle, last):	
	<input type="radio"/> AmeriHealth Caritas Pennsylvania <input type="radio"/> AmeriHealth Caritas Northeast	Member ID number:
	Date of EPSDT visit:	
Does the member need assistance locating a dental provider? <input type="radio"/> Yes <input type="radio"/> No		Does the member need assistance making an appointment? <input type="radio"/> Yes <input type="radio"/> No

<b>MEMBER</b>	<b>Member identification</b>	
	Member name (first, middle, last):	
	<input type="radio"/> AmeriHealth Caritas Pennsylvania <input type="radio"/> AmeriHealth Caritas Northeast	Member ID number:
	Date of EPSDT visit:	
Does the member need assistance locating a dental provider? <input type="radio"/> Yes <input type="radio"/> No		Does the member need assistance making an appointment? <input type="radio"/> Yes <input type="radio"/> No

<b>MEMBER</b>	<b>Member identification</b>	
	Member name (first, middle, last):	
	<input type="radio"/> AmeriHealth Caritas Pennsylvania <input type="radio"/> AmeriHealth Caritas Northeast	Member ID number:
	Date of EPSDT visit:	
Does the member need assistance locating a dental provider? <input type="radio"/> Yes <input type="radio"/> No		Does the member need assistance making an appointment? <input type="radio"/> Yes <input type="radio"/> No

<b>MEMBER</b>	<b>Member identification</b>	
	Member name (first, middle, last):	
	<input type="radio"/> AmeriHealth Caritas Pennsylvania <input type="radio"/> AmeriHealth Caritas Northeast	Member ID number:
	Date of EPSDT visit:	
Does the member need assistance locating a dental provider? <input type="radio"/> Yes <input type="radio"/> No		Does the member need assistance making an appointment? <input type="radio"/> Yes <input type="radio"/> No

Submitted by: \_\_\_\_\_ Phone number: \_\_\_\_\_

**Fax the signed and completed form to 1-215-937-7314. (Incomplete or illegible forms will be returned for correction.)  
If you have any questions or concerns, please call Provider Services at 1-800-521-6007 for AmeriHealth Caritas Pennsylvania  
or 1-888-208-7370 for AmeriHealth Caritas Northeast.**