

# Application Checklist for Practitioners



Submit this application checklist, either the Pennsylvania standard application or CAQH number, and all other accompanying documents to **provider.credentialinghbg@amerihealthcaritaspa.com** or fax to **1-717-651-1673**. Please alert your Account Executive when submitting credentialing documents. For more information, go to **www.amerihealthcaritaspa.com** or **www.amerihealthcaritasnortheast.com** → **Providers** → **Join our network**.

Please provide the following practitioner information:			
Applicant's full name:		Title:	
Practice name to appear in directory (doing business as [DBA]):			
Is this practice a			
<input type="checkbox"/> Federally qualified health center (FQHC)	<input type="checkbox"/> Rural health clinic (RHC)	<input type="checkbox"/> Mobile	<input type="checkbox"/> Tribal organization
<input type="checkbox"/> Indian tribe		<input type="checkbox"/> Urban Indian organization	
Are you contracted with AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast and AmeriHealth Caritas VIP Care? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Products: <input type="checkbox"/> AmeriHealth Caritas Pennsylvania/AmeriHealth Caritas Northeast (Medical Assistance)			
<input type="checkbox"/> AmeriHealth Caritas VIP Care (Medicare Advantage dual eligible special needs plan [D-SNP])			
<input type="checkbox"/> AmeriHealth Caritas Pennsylvania Community HealthChoices (long-term services and supports [LTSS])			
<input type="checkbox"/> All three			
Practice's Taxpayer Identification Number (TIN):	Group's National Provider Identifier (NPI) number:*	Applicant's NPI number:	
Individual Medicaid ID number:	Group Medicaid ID number:	CAQH-issued ID number (if applicable):	
Medicare ID number (if applicable; must have a Medicare ID number in order to participate with Medicare plan):			
<input type="checkbox"/> Primary care practitioner (PCP)	<input type="checkbox"/> Dentist	<input type="checkbox"/> Allied health	<input type="checkbox"/> Public Health
<input type="checkbox"/> Specialist	<input type="checkbox"/> Hospital-based only	<input type="checkbox"/> Behavioral health	Dental Hygiene Practitioner
Applicant's specialty:			
Credentialing contact name:	Credentialing contact email address:	Credentialing contact phone number:	
**Applicant's race (choose only one):			
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Middle Eastern/North African	
<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Some other race	
<input type="checkbox"/> Asian		<input type="checkbox"/> Decline to say	
**Applicant's ethnicity:			
	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Unknown or decline to say	
	<input type="checkbox"/> Non-Hispanic or Latino		
**Language(s) spoken by applicant and/or clinical staff:			

\* If provider is at more than one location, please attach a list of the group's NPI number for each location where the provider is providing services.

\*\* Providing race, ethnicity, and language information is optional. We collect this data to assist members in selecting a provider.



**Please provide the following:**

CAQH authorization allowing AmeriHealth Caritas to access practitioner information. **(Please ensure all current copies of the below supporting documents are updated on the CAQH application. Do not submit until all documents are current.)**

Non-CAQH participants must submit copies of the following support documents:

<input type="checkbox"/> Practitioner application (completed, signed, and dated).	
<input type="checkbox"/> State medical license.	
<input type="checkbox"/> Board certification (if applicable).	
<input type="checkbox"/> Certifications for the following practitioners (if applicable):	
<ul style="list-style-type: none"> <li>• (Behavioral health) Social Worker, Professional Counselor, and Psychologist.</li> <li>• Nurse Practitioner.</li> </ul>	<ul style="list-style-type: none"> <li>• Physician Assistant.</li> <li>• Nurse Midwife.</li> <li>• Public Health Dental Hygiene Practitioner.</li> </ul>
<input type="checkbox"/> Drug Enforcement Administration (DEA) registration certificate (if applicable).	<ul style="list-style-type: none"> <li>• DEA certificate must have the state in which the practitioner is rendering services to our members.</li> </ul>
<input type="checkbox"/> Controlled Dangerous Substances (CDS) certificate (if applicable).	
<input type="checkbox"/> Malpractice insurance policy face sheet showing expiration dates and limits of liability. (Provider's name must be on face sheet. If name is not included, a roster is required.)	
<input type="checkbox"/> CV/résumé (if applicable).	<ul style="list-style-type: none"> <li>• CV/résumé must cover five years of work experience with no gaps. Provide an explanation of any gaps greater than six months.</li> </ul>
<input type="checkbox"/> Clinical Laboratory Improvement Amendments (CLIA) certificate (if applicable).	
<input type="checkbox"/> Medicaid provider enrollment number. (We must have your individual PROMISe™ Provider Identification Number (PPID) number as well as a PPID number for each location, or proof that you have submitted an application. For applications in process with the Department of Human Services (DHS), please submit a copy of the first page and signature page of the application you submitted.)	
<input type="checkbox"/> Group PPID number.	
<input type="checkbox"/> W-9 form.	
<input type="checkbox"/> Hospital privileges indicating the practitioner's primary admitting hospital. Please forward a copy of a coverage agreement if the practitioner does not have admitting privileges or a letter stating hospitalist service used.	
<input type="checkbox"/> Practitioner's office hours (must be completed on the application).	
<input type="checkbox"/> Allied health professionals listed below are required to provide a Collaborative Agreement:	
<ul style="list-style-type: none"> <li>• Nurse Practitioner (NP).</li> <li>• Physician Assistant (PA).</li> </ul>	<ul style="list-style-type: none"> <li>• Osteopathic Assistant (OA).</li> <li>• Certified Nurse Midwife (CNM).</li> </ul>
<input type="checkbox"/> Ownership disclosure.	

To check the status of your application, or if you have questions or concerns regarding this process, please contact the AmeriHealth Caritas Credentialing department at [provider.credentialinghbg@amerihealthcaritaspa.com](mailto:provider.credentialinghbg@amerihealthcaritaspa.com). Please include provider's full name, facility name, TIN, and NPI number.

If you are new to AmeriHealth Caritas and you or your group do not have a provider contract, you must first call AmeriHealth Caritas Pennsylvania at **1-800-521-6007** or AmeriHealth Caritas Northeast at **1-888-208-7370** to discuss obtaining an AmeriHealth Caritas Provider Agreement.

If you are a PCP, OB/GYN, general dentist, or pediatric dentist, our Provider Network department will contact you to schedule a site visit at your office(s).