AmeriHealth Caritas New Mexico

Provider Contract Inquiry Form

Please select all plans you would like to join:

☐ All
☐ Medicare Advantage dual-eligible special needs plan (DSNP)
☐ Health Insurance Marketplace (ACA)
☐ Medicaid Managed Care (MMC)

Date:

Completed form and W-9 should be returned to:

Name: Email:

Specialty:

☐ Primary care provider (PCP)
☐ Specialist
☐ Ancillary
☐ Behavioral health
☐ Hospital
☐ Dental
☐ Vision
☐ Long-term care/Home- and community-based services
☐ Other

Group or provider information

Legal entity name (W-9):	
Tax ID number (TIN):	Group NPI:
CAQH number (if applicable):	Medicaid number:
Legal entity signatory:	
Legal entity signatory title:	

Notice correspondence information

Legal notice of mailing address, including contact name:

Contact information for contract processing

Contact name:	Title:
Primary address:	
Fax:	Taxonomy code:
Mailing address:	
☐ Check if primary address is the same as mailing address	
Contact telephone:	Contact email: