AmeriHealth Caritas
Louisiana

## Provider Directory New Patient Acceptance Form

**Please complete this form to help us keep correct information for our members and your patients.**

**Provider's Name:** _____

**Business/Facility Name:** _____

**Provider's NPI:** _____ **Federal Tax ID #:** _____

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**How you answer the following questions will determine how you are listed in the AmeriHealth Caritas Louisiana (ACLA) Provider Directory.**

1. Are you accepting ACLA members as new patients? Yes No
2. Are you accepting ACLA members as established patients? Yes No
3. Are you accepting ACLA as primary insurance? Yes No
4. Are you accepting ACLA as secondary insurance? Yes No
5. Are you accepting ACLA at all locations? Yes No

   If *No*, please list the locations that **do** accept ACLA: _____

   _____

**Signature:** _____ **Date:** _____

**Printed Name:** _____

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**If you would like to make a <u>change</u> to how you are <u>currently</u> listed in ACLA's Provider Directory, please answer the questions below.**

1. Are you accepting ACLA members as new patients? Yes No
2. Are you accepting ACLA members as established patients? Yes No
3. Are you accepting ACLA as primary insurance? Yes No
4. Are you accepting ACLA as secondary insurance? Yes No
5. Are you accepting ACLA at all locations? Yes No

   If *No*, please list the locations that **do** accept ACLA:

   _____

   _____

**Signature:** _____ **Date:** _____

**Printed Name:** _____