Contract Request Form

AmeriHealth Caritas Louisiana

Required fields are marked with an asterisk (*).

Contact first name*:	Contact last name*:	
Contact phone number*:		
Contact email address*:		
Provider demographics		
Legal entity name*:		
Street address*:		
Address line 2:		
Attention*:		
City*:	State*:	ZIP*:
Email:	Phone:	Fax:
Provider indentification numbers		
Tax ID*:	NPI*:	
Medicaid number*:		
Type of provider		
Provider type: Ancillary		
Physician specialty:		
If physician, will you function as a PCP?:		
Facility type (if applicable):		
Ancillary services rendered (if applicable):		

Please email this contract request form to:

Email: **providerenrollment@amerihealthcaritasla.com**