Contract Initiation Form

Please complete and email this form along with a copy of your W-9 to: PHWcontracting@PaHealthWellness.com

Legal Provider name as it appears on W-9:	
W-9 (Copy must be included)	
Provider signing authority email address:	
TAX ID #	
Provider street address:	
City:	
State:	
ZIP:	
NPI #	
Medicare #	
Medicaid #	
ATTN: (Individual to whom it will be addressed)	
Notices email:	

↓ Check all that apply		
Contract request for:		Medicaid
		Medicaid/Medicare (Duals if applicable) *(Please note this is for facility eligibility and does not reference participant eligibility. Only check if you can bill both Medicaid and Medicare for your services.)*
		Exchange
Ancillary Provider:		DME
		Home Health/Hospice
		LTSS
		Ambulance
		Ambulatory Surgery
		Chemotherapy
		Dialysis
		Urgent Care
		Home Infusion
		Imaging/Radiology
		Laboratory
		Physical Therapy
		Prenatal Care Coordination
Facility Provider:		FQHC
		Nursing Facility
		Rural Health Center
		Clinic Facility
		FQHC - Dental
Professional Provider:		IPA
		Medical Group
		Physician Hospital Organization
		Physician Organization
		Primary Care Physician
		Specialty Care Physician