Contract Initiation Form

Please complete and email this form, any supplemental information, and a copy of your W-9 to:
PHW_LTSSContracting@PaHealthWellness.com

Requestor Name and Email:	

Legal Provider Name: (Name as it appears on the W-9)	
Tax ID #:	
NPI #:	
Primary Street Address:	
City, State, ZIP:	
County:	
Medicare #:	
Medicaid #:	
Legal Notices Address:	
Legal Notices Email:	
ATTN: (Individual Name and/or Title to whom Notice will be addressed)	
Contract Signer Name and Title:	

Please Check all that Apply		
Contract Request for:		Medicaid (Health Choices and Community Health Choices)
		Medicare (Wellcare by Allwell)
		Exchange (Ambetter)

Provider's Specialty:			
	Durable Medical Equipment (DME)		Prosthetics & Orthotics
	Home Health Agency		Skilled Nursing Facility
	Hospice		LTSS (Home & Community Based Services)
	OTHER:		
	List DME Specialized Services or Products:		

Home Care & Personal Assistance Services ONLY
What counties can you accept referrals and have sufficient staff for coverage?
Staffing related:
a. What is your full time equivalent (FTE) staff count?
b. How many FTEs are available on any given day including weekends or holidays?
c. Are staff available to take split shifts in servicing county?
Proficient in speaking languages other than English (list):
Can a bariatric case or other specialized care be supported if needed? ___Y ___N (describe)