

Contract Request Form

(Please complete one form per Practitioner, Mid-level)

Date: _____

Practice Group Name: _____

IPA/PHO Affiliation: _____

Provider Name First: _____ / Last Name: _____ / Degree _____

Provider Gender: Male Female Email Address: _____

Provider Primary Language _____ Secondary Language _____

Contract Request

- New Contract
 Adding New Provider/Mid-Level to Practice

Provider Type

- Physician - List Primary Specialty _____ / Sub-Specialty _____
 Hospital Based Provider
 Physician Assistant Physician you support _____
 Nurse Practitioner Physician you support _____
 Ancillary Type _____
 Other: _____

Contact/Manager: _____ / Telephone # _____

Provider TIN # _____ Provider Medicaid # _____

NPI # _____ Office Location _____

City _____ / State _____ / Zip Code _____ / County _____

Telephone Number _____ / Fax Number _____

(For additional locations, please attach any extra page (s) to include Medicaid numbers for each location.)

PLEASE FAX REQUEST (S) TO ATTENTION: CONTRACTING DEPARTMENT AT 866-532-8869

[THIS IS NOT A CREDENTIALING APPLICATION, CONTRACT OR GUARANTEED ENTRY INTO THE PEACH STATE NETWORK](#)