CareSource

New Contract Information Form

Date	
Group Name	
Group TIN	
Group NPI	
Group Medicare	
Group Medicaid	
Product: Medicaid and/or SNP	
Contact Name	
Contact Phone	
Contact Email	
Signatory Name	
Signatory Title	
Mailing Address, City, St, Zip	
Remit Name, Address, City, St, Zip	
Notes:	

CareSource

New Contract Information Form

Provider Information

Name	Deg.	Address	City	ST	Zip	Phone	Fax	NPI #	CAQH#	Medicaid #	Medicare #	Specialty	PCP? Y/N	If Yes, Capacity? (Min. 50)
John Doe (SAMPLE)	MD	123 Main St	Anywhere	OH	45123	937-555-1212	937-555-1212	1231231291	123456	1234567	1234567	FP	Y	50

Important: Please include W-9 and ensure all CAQH applications are updated and accurate to ensure timely processing of providers.

Return to: NewContract@CareSource.com