Request for New Contract – Hierarchy Form

Date								
Group IRS Name (Line one on W-9)								
Group DBA								
Group TIN								
Group NPI								
Group Medicare								
Group Medicaid								
Product:	☐ Medicaid Only	☐ Medicaid and SNP	☐ SNP Only	☐ ICDS				
Office Contact								
Contact Name								
Contact Phone								
Contact Email								
Please indicate if you are:	☐ FQHC	☐ RHC	☐ QFPP	☐ CHMC				
Contract								
Signatory Name								
Signatory Title								
Signatory Email								
Address								
Remit Name								
Remit	**Street**		**City**		**State**		**Zip**	
Mailing ☐ Same as avove	**Street**		**City**		**State**		**Zip**	
Contractual Updates ☐ Same as avove	**Street**		**City**		**State**		**Zip**	
Notes:								

For Internal Use Only: Medicaid Agreement ID _____

For Internal Use Only: Medicare Agreement ID _____

Name	Race/ Ethnicity	Deg.	Address	City	ST	Zip	County	Phone	Fax	NPI #	CAQH#	Medicaid #	Medicare #	Specialty	PCP ? Y/N	If Yes, Capacity
John Doe (SAMPLE)	*See below	MD	123 Main St	Anywhere	OH	45123	Greene	937-555-1212	937-555-1212	1231231291	123456	1234567	1234567	FP	Y	100

Provider Information

*Race/Ethnicity = Asian, Black or African American, Hispanic or Latino, American Indian, White, Other, Choose Not to Answer

Please insert rows if more lines are needed.

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