Contract Initiation Form

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

Requestor Name:	
Requestor Email:	
Requestor Phone #:	

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:	
Contract Signer Email:	

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

Provider's Type:			
☐	Ancillary	☐	HCBS/LTSS
☐	Facility/Hospital	☐	Physician/Professional
☐	Behavioral Health Professional	☐	Behavioral Health Facility
☐	OTHER:		