Provider Practice Name: _____

Practice Address: _____

Date: _____

Adding New Provider to Existing Contract

This form authorizes Wellcare to load the list of providers below to the following:

Practice (Group) Name:		**Primary Location Address**	
Group NPI:		**Tax ID:**	
Pay to (Vendor) Name & Address		**Correspondence Address:**	

Practice Website: _____

Provider to be loaded for Line of Business: Medicaid ☐ Medicare ☐ Ambetter ☐

Do you offer Telemedicine Services? Yes ☐ No ☐

Do you participate with KHIE (Kentucky Health Information Exchange)? Yes ☐ No ☐

Does this practice have a CLIA? Yes ☐ No ☐

If yes, please include CLIA #, term date & copy of certificate: _____

Provider Name	Effective Date	Labs Y / N	NPI	PCP Y / N	CAQH	KY Medicaid	KY Medicare	Taxonomy	Additional Address Y/N

For 15 or more providers, please complete a roster. Your Provider Relations Representative can provider you a template.

Section 2: Additional locations – please indicate if covering location only.							
Organization / Practice Name							
Physical Address							
City				**State**		**Zip + 4**	
Telephone:			**Fax**		**Email:**		
Is this a Practice location?	YES ☐ NO ☐	**Is this a Covering Location?**	YES ☐ NO ☐		**Telehealth?**	YES ☐ NO ☐	
Handicap Access	YES ☐ NO ☐	**Bus Route**	YES ☐ NO ☐	**TDD**	YES ☐ NO ☐	**Open Panel**	YES ☐ NO ☐
Office Hours	**Sunday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
From							
To							

Additional location							
Organization / Practice Name							
Physical Address							
City				**State**		**Zip + 4**	
Telephone:			**Fax**		**Email:**		
Is this a Practice location?	YES ☐ NO ☐	**Is this a Covering Location?**	YES ☐ NO ☐		**Telehealth?**	YES ☐ NO ☐	
Handicap Access	YES ☐ NO ☐	**Bus Route**	YES ☐ NO ☐	**TDD**	YES ☐ NO ☐	**Open Panel**	YES ☐ NO ☐
Office Hours	**Sunday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
From							
To							

Additional location							
Organization / Practice Name							
Physical Address							
City				**State**		**Zip + 4**	
Telephone:			**Fax**		**Email:**		
Is this a Practice location?	YES ☐ NO ☐	**Is this a Covering Location?**	YES ☐ NO ☐		**Telehealth?**	YES ☐ NO ☐	
Handicap Access	YES ☐ NO ☐	**Bus Route**	YES ☐ NO ☐	**TDD**	YES ☐ NO ☐	**Open Panel**	YES ☐ NO ☐
Office Hours	**Sunday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
From							
To							

Please e-mail the completed form to your Provider Relations Representative.

Sincerely,

Requesters Name:_____

Title: _____

Email: _____Phone: _____