

Contract Information: *The information you provide below will be printed on the Agreement and will be used to mail/email any Contractual Notices (Regulatory Updates, Amendments, etc...)*
This form and the information you provide is used by Sunshine Health to evaluate the offering of a Contract and is not representative of an application or a Legal Agreement.

Products: Medicaid Child Welfare Specialty Plan Children's Medical Services Serious Mental Illness Plan
 Long Term Care Medicare Commercial Exchange (*Ambetter*) Behavioral Health

Date: _____ **Specialty:** _____ **Ages Seen:** _____

Legal Name: *(as it appears on W-9):* _____

D/B/A *(doing business as):* _____

Tax ID: _____ **Group Medicaid #:** _____ **Group Medicare #:** _____

Billing NPI: _____ **Group Taxonomy:** _____

Recipient: _____ **Title:** _____
(individual/department to whom notices will be mailed)

Email: _____ **Phone:** _____
(the contract will be sent to this email)

Address: _____
(future contractual notices will be mailed to this address)

City: _____ **ST:** ____ **Zip:** _____ **County:** _____

Primary Location: _____ **Practice Website:** _____

After Hours Coverage? Yes No **Telemedicine Services?** Yes No

Accredited Practice? Yes No **Accreditation Agency:** _____

Patient Centered Medical Home (PCMH)? Yes No

PCMH Accreditation/Recognition Program: NCQA AAAHC TJC URAC Other _____

NCQA Behavioral Health (BH) Integration Distinction? Yes No

NCQA Patient Centered Specialty Practice? Yes No

To Be Completed By Sunshine Health V. 06/01/2022

New Repaper Amendment # ____ Sent _____ Recvd _____ Deviated Rates Lang

ECM # _____ **1st Sig Date** _____ **Effective Date** _____

Products: MMA CW CMS SMI LTC MCR EX BH HK **W9 Date:** _____

Base ECM # _____ **Base 1st Sig Date** _____ **Base Eff Date** _____

Base LOBs: MMA CW CMS SMI LTC MCR EX BH HK **CenProv ID:** _____