CONTRACT REQUEST FORM

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 ☐HIV/AIDS Specialty 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. 07/08/2024

☐New ☐Repaper ☐Amendment # ____ Sent _____ Recvd_____ Deviated ☐Rates ☐Lang

ICM # _____ 1st Sig Date _____ Effective Date _____

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

Base ICM # _____ Base 1st Sig Date _____ Base Eff Date _____

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