Provider Practice Name: ______________________________

Practice Address: ______________________________

Date: ______________________________

Adding New Provider to Existing Contract

This form authorizes WellCare of Kentucky 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: ______________________________

Revised: 02.01.2023

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.

Revised: 02.01.2023

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							

Revised: 02.01.2023

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: __________________

Revised: 02.01.2023