



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



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 <input type="checkbox"/> NO <input type="checkbox"/> | Is this a Covering Location? | | YES <input type="checkbox"/> NO <input type="checkbox"/> | Telehealth? | |
| Handicap Access | | YES <input type="checkbox"/> NO <input type="checkbox"/> | Bus Route | | YES <input type="checkbox"/> NO <input type="checkbox"/> | TDD | |
| Open Panel | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 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 <input type="checkbox"/> NO <input type="checkbox"/> | Is this a Covering Location? | | YES <input type="checkbox"/> NO <input type="checkbox"/> | Telehealth? | |
| Handicap Access | | YES <input type="checkbox"/> NO <input type="checkbox"/> | Bus Route | | YES <input type="checkbox"/> NO <input type="checkbox"/> | TDD | |
| Open Panel | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 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 <input type="checkbox"/> NO <input type="checkbox"/> | Is this a Covering Location? | YES <input type="checkbox"/> NO <input type="checkbox"/> | Telehealth? | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| Handicap Access | YES <input type="checkbox"/> NO <input type="checkbox"/> | Bus Route | YES <input type="checkbox"/> NO <input type="checkbox"/> | TDD | YES <input type="checkbox"/> NO <input type="checkbox"/> | Open Panel | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 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