Amerigroup
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https://providers.amerigroup.com

Group Application and Release Form

Provider identification			
Group name:			
Street address (no P.O. Box):			
City:	State:	ZIP code:	County:
Phone:		Fax:	
Are you a(n): ☐ Federally qualified health center (Y8)? ☐ Urgent care center (ZK)?		☐ Rural health clinic (YO)? ☐ Texas approved nonprofit health corporation?	
Are claim payments made to: ☐ The group?		☐ The individual?	
Does your group consist of: ☐ PCPs?		☐ Specialists?	☐ Both?

If payment is made to the group, please provide the following:	**Are there subgroups covered by this group contract? If so, please list them below.**
Billing name:	Group name:
Street/suite/P.O. Box:	Tax ID: NPI:
City, State ZIP code:	Group name:
Phone:	Tax ID: NPI:
Fax:	Group name:
Tax ID: NPI:	Tax ID: NPI:
Please enclose a copy of your claims forms.	**If additional groups exist, please list name, Tax ID and NPI on a separate sheet.**

Number of physicians and other practitioners in this group:

Enclosures

Please submit the following with your completed and signed application:

1. A copy of your state facility license(s)
2. A copy of your *Liability Insurance Policy* face sheet with expiration dates and amounts
3. A copy of your NPI confirmation notice for each NPI listed
4. For urgent care centers: a copy of facility accreditation or recent (within 24 hours) Health Care Financing Administration or state review if not accredited

Attestation and information release authorization

All information provided in this or in connection with this application is complete and accurate to the best of my knowledge, and I shall immediately notify Amerigroup District of Columbia of any changes thereto. I understand that this application does not entitle the provider to participate in the Amerigroup network. By applying to be an Amerigroup participating provider, the plan, its medical director and appropriate representatives may consult with other institutions, including past and present malpractice carriers. I hereby further consent to the inspection by Amerigroup, its medical director and appropriate representatives of all records and documents that may be material to an evaluation of professional qualifications and competence. I hereby release Amerigroup and its representatives from liability for their acts performed in good faith and without malice in connection with evaluating this provider's application, credentials and qualifications. I hereby release any individuals and organizations from any liability that provide information to Amerigroup or its staff in good faith and without malice concerning competence and other qualifications, and I hereby consent to the release of such information.

Name:	Title:
Signature:	Date: