



Practitioner Group Addition Form

This form is used to add any practitioner to a new group or to an already in-network group (including currently in-network individually contracted practitioners).

(Please check all boxes that apply)

Provider Name: _____

Provider Licensure: _____

Carelon Behavioral Health provider number: _____

Provider NPI: _____

Provider CAQH#: _____

I wish to be contracted under the group agreement for:

Group Name: _____

Group Tax ID: _____

Carelon Behavioral Health Group provider number: _____

*Please indicate the **Group** Locations below (Please submit copies if additional locations needed)

Practice address: _____	Billing address: _____
Line 2: _____	Line 2: _____
City: _____	City: _____
State: _____ ZIP: _____	State: _____ ZIP: _____
Phone #: _____ Fax #: _____	Phone #: _____ Fax #: _____
M: _____ T: _____ W: _____ Th: _____ F: _____ Sa: _____ Su: _____	

Practice address: _____	Billing address: _____
Line 2: _____	Line 2: _____
City: _____	City: _____
State: _____ ZIP: _____	State: _____ ZIP: _____
Phone #: _____ Fax #: _____	Phone #: _____ Fax #: _____
M: _____ T: _____ W: _____ Th: _____ F: _____ Sa: _____ Su: _____	



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- I wish to terminate my Carelon Behavioral Health individual practitioner agreement and no longer be in-network at any non-group service location.
- I will maintain my Carelon Behavioral Health individual practitioner agreement and remain in-network at my private practice and/or individually contracted service locations at the following service locations:

*Please indicate your **Private Practice/Individually Contracted** locations below (Please submit copies if additional locations needed)

Practice address: _____	Billing address: _____
Line 2: _____	Line 2: _____
City: _____	City: _____
State: _____ ZIP: _____	State: _____ ZIP: _____
Phone #: _____ Fax #: _____	Phone #: _____ Fax #: _____
M: _____ T: _____ W: _____ Th: _____ F: _____ Sa: _____ Su: _____	

Practice address: _____	Billing address: _____
Line 2: _____	Line 2: _____
City: _____	City: _____
State: _____ ZIP: _____	State: _____ ZIP: _____
Phone #: _____ Fax #: _____	Phone #: _____ Fax #: _____
M: _____ T: _____ W: _____ Th: _____ F: _____ Sa: _____ Su: _____	

Name (please print): _____

Signed: _____

Date: _____

**** Attention group administrators: Please submit this form with an updated group roster. ****

Please submit your completed form to: Carelon Behavioral Health, PO Box 989, Latham, NY, 12110 Fax: 866-612-7795.