INSTRUCTIONS:

Please submit this completed form and the required attachments to **PositiveContractingDept@ahf.org**. Incomplete forms will be returned for completion prior to processing. Please return this form and all applicable attachments.

Join Our Network Form

1. ORGANIZATION INFORMATION: *(Provide physical location information on the following page)*	
Legal Name of Organization (Legal name listed with the IRS)	
DBA Name of Organization (if applicable)	
Historic Name(s) of Organization (if applicable)	
Organization Medicare # *(primary)*:	Medicaid # or Medi-Cal #*(primary)*:
Organization TIN *(primary)*:	Organization NPI *(primary)*:
Contract Contact	**Address** *(if multiple, include organizations roster)*
Street Address: ______	Street Address: ______
Address Line 2: ______	Address Line 2: ______
City: State: Zip:	City: State: Zip:
Contact Name: ______	Contact Name: ______
Email: ______	Email: ______
Phone: ______ Fax: ______	Phone: ______ Fax: ______

2. General Information	
☐ Please check here if your PAVE application is pending approval *(applicable to California Providers)*	
CAQH ID Number:	Fax Number:
County and State:	Website:
Primary Specialty:	Secondary Specialty:

COMPLETE THE BELOW INFORMATION FOR EACH PRACTICE LOCATION

Only include information for locations that you wish to be listed.

3. PHYSICAL LOCATION INFORMATION:

(Include any additional information relevant to this location on a separate sheet)

Location DBA
(if different than the Organization DBA)

Other DBAs Previously Used
(if under same ownership)

Is this location Medicare Certified? ☐ **Yes** ☐ **No**	Is this the primary address? ☐ **Yes** ☐ **No**
Site-specific Medicare #:	Site-specific Medicaid #:
Site-specific TIN:	Site-specific NPI:
Physical Practice Location	State provider # *(if applicable, LTC, etc.)*:
Street Address:	Is this location handicap accessible? ☐ **Yes** ☐ **No**
Address Line 2: ______________________	**How did you hear about us?**
City:______________State:__________Zip: __________	
Phone:________________Fax: ______________	

Please list any languages spoken by office personnel:

Practice Limitations (e.g., age, gender, etc.):

Location State License(s) and/or State Registration(s) – *(Attach a copy of all)*

☐ *Please check here there is more than (1) service location, please attach listing. Ensure to capture full address, hours of operations, and practice limitations(e.g., ages, gender, etc.) for each location.*

Type of Credential	State	Number	Medicaid/Medi-Cal #	Additional Notes/Info
State License				
State Registration				
State Certification				
Other:				

Additional Location Credentials – *(Attach a copy of all)*

☐ *Please check here if this location holds no additional licenses, certificates, registrations, etc.*

Type of Credential	State	Number	Expiration Date	Additional Notes/Info
DEA				
CLIA				
Provider Degree Type(e.g., MD, DO, NP)				
Provider Primary Board Certification Type				

Specialty & Federal Taxonomy Code

Name of Hospital(s) where privileged (*if applicable*)

Join Our Network Form

Patient Service Area(s)*(check all that apply)***:**		
☐ *Please check here if you are affiliated or associated with a Ambulatory Surgery Facilities.*		
☐ *Please check here if your organization is NOT accredited and NOT required to be surveyed by ANY organization.*		
Please select your organization's service area by marking the box next to the counties		**Name of affiliated Hospital or Ambulatory Surgery Facilty**
☐ (Statewide)	National areas	
☐ (CA)	Los Angeles County	
☐ (FL)	Broward County	
☐ (FL)	Miami-Dade County	
☐ (FL)	Duval County	
☐ (Other)	Name of County:	
☐ (Other)	Name of County:	
☐ (Other)	Name of County:	
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