PerformCARE®
8040 Carlson Road
Harrisburg, PA 17112

MD/DO IN NETWORK QUESTIONNAIRE

****You MUST have MA prior to completing this form for the practitioner and/or group****

Practitioner Name: _____

☐ Payment going to practitioner

☐ Payment going to Group

If payment is going to Group

☐ Group Name: _____

Contact Name: _____

Contact Phone: _____

Contact Email: _____

Full address where services will be rendered (including county):

_____

Contracts requested (check all that apply):

☐ CABHC (Capital Region- Cumberland, Dauphin, Lancaster, Lebanon, Perry counties)

☐ TMCA (Franklin and Fulton counties)

Medicaid enrollment:

MAID Number for the practitioner: _____

MAID Number for the group: _____

Services being requested (level of care):

_____

Place of service provided (check all that apply):

☐ Office ☐ Telehealth