PerformCARE®
8040 Carlson Road
Harrisburg, PA 17112

MD/DO/CRNP 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): (Please attach additional pages for any other service locations and include MA numbers for your group and practitioner).

_____

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 (Must be in compliance with OMHSAS 22-02)