CareFirst
Family of health care plans

Ambulance Application Questionnaire

Complete this form to be considered for participation in our provider network(s).

Please attach the following: **W-9, License, Malpractice Insurance**

General Information			
Group Name			
Service Specialty	Ambulance Service	Provider Type	Ambulance
Tax Identification		Billing NPI (Type 2)	
Authorized Office Manager/Contact Person		Job Title	
First Name		Last Name	
Phone Number	Extn	Email Address	

Licenses		
License Name	State	Date of Issuance

Insurance			
Insurance Name	Policy Number	Coverage Type	Aggregate
Occurrence Amt	Aggregate Amt	Effective Date	Expiration Date

Tax Address (to receive 1099 form)			
Street Address		Telephone Number	
City	State	County	Zip Code

Mailing Address (to receive claim forms, publications and other correspondence)			
Street Address		Telephone Number	
City	State	County	Zip Code

Payment Address, if different from above (to receive reimbursement checks)			
Street Address		Office Telephone Number	
City	State	County	Zip Code

Primary Service Location		Effective Date	
Street Address		Location Telephone Number	
City	State	County	Zip Code

Additional Service Locations

Service Location		Effective Date	
Street Address		Location Telephone Number	
City	State	County	Zip Code

Service Location		Effective Date	
Street Address		Location Telephone Number	
City	State	County	Zip Code

Service Location		Effective Date	
Street Address		Location Telephone Number	
City	State	County	Zip Code

Service Location		Effective Date	
Street Address		Location Telephone Number	
City	State	County	Zip Code

Service Location		Effective Date	
Street Address		Location Telephone Number	
City	State	County	Zip Code