

## **Provider Directory New Patient Acceptance Form**

Please complete this form to help us keep correct information for our members and your patients.

Busin	ess/Facility Name:		-
Provi	der's NPI: Federal Tax ID #:		
_	you answer the following questions will determine how you iHealth Caritas Louisiana (ACLA) Provider Directory.	ou are li	sted in the
1.	Are you accepting ACLA members as new patients?	Yes	No
2.	Are you accepting ACLA members as established patients?	Yes	No
3.	3. Are you accepting ACLA as primary insurance?		No
4.	Are you accepting ACLA as secondary insurance?	Yes	No
5.	Are you accepting ACLA at all locations?	Yes	No
	If <i>No</i> , please list the locations that <b>do</b> accept ACLA:		
Signa	ture: Date:		
	240.		
	ed Name:		
If you		·	
If you Direc	would like to make a <u>change</u> to how you are <u>currently</u> list	·	
If you Direc 1.	would like to make a <u>change</u> to how you are <u>currently</u> list tory, please answer the questions below.	ted in A	CLA's Provide
If you Direc 1. 2.	would like to make a <u>change</u> to how you are <u>currently</u> list tory, please answer the questions below.  Are you accepting ACLA members as new patients?	ted in A	CLA's Provide
If you Direc 1. 2.	would like to make a change to how you are currently list tory, please answer the questions below.  Are you accepting ACLA members as new patients?  Are you accepting ACLA members as established patients?	t <b>ed in A</b> Yes Yes	CLA's Provide No No
If you Direc 1. 2. 3. 4.	would like to make a change to how you are currently list tory, please answer the questions below.  Are you accepting ACLA members as new patients?  Are you accepting ACLA members as established patients?  Are you accepting ACLA as primary insurance?	Yes Yes Yes Yes	CLA's Provide  No  No  No

Signature:	Date:	
Printed Name:		