

Contract Application

Contract Typ	De: Medicaid Medicare	Both Medicaid &	Medicare							
Practice Nan	ne:				Prov	vider Typ	e: 🗌 P(CP Special	ist	/ Facility
Legal Entity	Name:									
Group NPI (10 char), if applicable:		Group/Solo TIN/EIN # (9 char):								
Contact Person:			Contact Email:							
	Practice Name (as it will appear in Provider Directory)	Street Address	Bldg # and/or Ste #	City	State	Zip Code	County	Telephone w/ Area Code	Fax Number w/ Area Code	Email
Practice Location 1										
Practice Location 2										
Practice Location 3										
Practice Location 4										
Practice Location 5										
Practice Location 6										
Practice Location 7										
Practice Location 8										

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Email to: provider.contracting@keystonefirstpa.com or fax to: 215-863-5472



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Confirm Group/Solo TIN/EIN # (9 char.):	
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First Name	Last Name	MI	Degree	Specialty	CAQH Reg. # (List N/A if provider is not registered)	Individual NPI # (10 characters)	PPID #*	Practice Location (Insert Practice #)

^{*} Enrollment in the PA Medical Assistance Program is required in our Medicaid Product. If you are not enrolled and do not have PPID we cannot credential you for participation. If you need to enroll, please call the Department of Public Welfare (DPW) at 1-800-537-8862.