Contract Application

Please type in each field. Handwritten forms will not be accepted.

Keystone First
Family of Health Plans

Contract type: Select applicable plan(s). ☐ Medicaid	☐ Medicare	☐ CHC	☐ CHIP	☐ **W9 attached** (signed within last 180 days)	
Provider type: ☐ PCP	☐ Specialist — provider type:			☐ Ancillary	☐ Facility
Legal entity name:*			Group NPI:*	Group TIN:*	
Contracting contact name:*		Phone:*	Email:*		
Credentialing contact name:*		Phone:*	Email:*		

Practice locations	**Practice name** (as it will appear in the directory)		**Street address** (as it will appear in the directory)		**City**	**ST**	**ZIP**
	Phone	**Fax**	**Group PROMISe ID# ****	**Group Medicare ID# †**	**County**		
Primary (all fields required)							
Location #2							
Location #3							
Location #4							
Location #5							
Location #6							
Location #7							
Location #8							
Location #9							

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

* Required

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

† Enrollment in Medicare is required in our Medicare Product. If you are not enrolled and do not have a Medicare ID, we cannot contract or credential you for participation. If you need to enroll, please complete the online PECOS application through the Centers for Medicare & Medicaid Services (**www.cms.gov > Medicare > Enrollment & renewal > Providers and suppliers**).

January 2026

Confirm Group/Solo TIN/EIN # (9 characters): _____

First name	Last name	MI	Medical degree	Specialty	CAQH Reg. # (list N/A if provider is not registered)	Individual NPI # (10 characters)	PA PROMISe ID#* (13 characters)	Medicare ID # (if applicable)

First row is required. Email to **provider.contracting@keystonefirstpa.com** or fax to **215-863-5472.**

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Questions (please complete ALL questions)**:**	
How are you submitting claims?	☐ CMS 1500 ☐ UB04
Do you have valid PROMISe ID #s for your group and all providers at ALL service/office locations?	☐ Yes ☐ No ☐ N/A — Medicare only
How many providers are you looking to credential with our plans?	
Are you billing J codes?	☐ Yes ☐ No
Are you billing adult immunizations/vaccinations?	☐ Yes ☐ No
Are you administering VFC immunizations?	☐ Yes ☐ No
Which type(s) of therapy do you provide?	☐ PT ☐ ST ☐ OT ☐ N/A
Which place(s) of service do you evaluate and treat patients?	☐ Office ☐ Hospital ☐ Other:
Do you provide telehealth services?	☐ Yes ☐ No
Do you provide or prescribe DME?	☐ Provide ☐ Prescribe ☐ N/A
Radiology Services: Do you bill Total Component, Technical Component, Reading Component?	☐ Total ☐ Technical ☐ Reading ☐ N/A
Radiology Equipment: If you have such equipment, please provide current certifications for same.	☐ Certifications attached ☐ N/A
Laboratory Services: If you have services above reagent tests, please provide CLIA certification(s).	☐ Certifications attached ☐ N/A
Urgent Care: Are you an Accredited Urgent Care? If so, please provide accreditations.	☐ Accreditations attached ☐ N/A
FQHC/RHC: Please provide the current PPS rate letter for each location.	☐ PPS rate letter(s) attached ☐ N/A
Pediatric Shift Care: Skilled nursing/support for children with complex medical needs in their home or residence?	☐ Yes ☐ No ☐ N/A
Addiction Medicine: Are you recognized as a Center of Excellence or do you provide medication-assisted treatment?	☐ COE ☐ MAT ☐ N/A
Oral Surgery: What do you bill? CPT, CDT, or both?	☐ CPT ☐ CDT ☐ Both ☐ N/A

Internal only		
# of providers in region:	Adequacy met? ☐ Yes ☐ No ☐ N/A	
Justification:		
Manager name:	Approved/Denied:	Date:

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