



Unlicensed AFL Site Enrollment Request

Incomplete Forms Will Be Returned

Date of Request: _____

Provider Legal Name: _____

Provider Address: _____ City: _____ State: _____ Zip+4: _____

Contact Person: _____

Phone: _____

Email: _____

Federal Tax ID: _____

UNLICENSED AFL HOME REQUESTED TO BE ADDED:

Address: _____ City: _____ State: _____ Zip+4: _____

NPI Number that will be used for billing: _____

CONSUMER INFORMATION *(for the Innovations enrollee you plan to admit to this unlicensed AFL):*

Name: _____
(First) *(Last)*

Date of Birth: _____

Medicaid ID#: _____ Medicaid County: _____

Alliance IDD Care Coordinator's Name: _____

Anticipated Date of Admission: _____

COMMENTS: _____

Person Completing Form: _____
(Signature)

Submit Completed Form to: ProviderNetwork@alliancebhc.org
Site is not approved until Agency receives approval letter from the Alliance Credentialing Department.
Addition of the site to your contract does not guarantee referrals or authorizations.