Dear Provider,

Thank you for your interest in joining the Community Care Plan Provider Network.

Please provide the following information so that we can process your request.

First and Last Name of the provider:
Provider's email address:
Contact Person: Name, Email Address and Phone Number:
Tax ID:
NPI:
W-9:
Line of Business(es) that you are interested in (MMA,T19, T21):
Specialty:
Population Served (Adult/Child):
Service Area:
How would you like to receive your documents (email or mail)?
Are you a new provider?
Are you part of a contracted provider?
Do you have a Medicaid Provider ID? If yes, please provide.

Please click on the following email link to send us the information above.

CCP Credentialing Department LOI

If you experience any problems with the link, please submit your information to the following email address:

credentialingdept@ccpcares.org

Thank you,

CCP Credentialing Department