

Off Cycle Concierge Provider Questionnaire Form

I am completing this Off-Cycle Concierge Provider Questionnaire Form to notify AmeriHealth that I am or will be practicing concierge medicine (or retainer medicine) and charging my patients a concierge fee (or retainer) separate from the applicable patient cost-sharing (e.g., co-pays, deductibles, etc.). My responses below reflect the scope of my concierge practice.

1. Did you offer concierge services to your patients prior to January 1, 2025?

- Yes
- No

2. Is your concierge fee for additional services optional for your existing patients?

- Yes
- No

3. Will you accept new patients who **are not** enrolled in concierge services and **are not** paying the concierge fee?

- Yes
- No

4. Please list below or attach a list of the Concierge Services you are providing.

Provider Name	
Provider NPI	Practice/Group Name

X
Your signature

 / /
Date (mm/dd/yy)

Reminder: Please remember to complete the Concierge Attestation.

