



Provider Enrollment Form

Practitioner Contact

CAQH ID #	15946049
Practitioner NPI #	1821669961
Provider Type	1) I am a new individual / solo practitioner.
Be Part Of A Group	True
Contract With Carelon	
Be Part Of A Group Type	In-Network group.
Group NPI	1033759592
Group Tax ID	844207450
Carelon Group ID	
How does the practitioner want to be contracted? Be contracted under the group above and	
Carelon Practitioner ID	
Practitioner's Last Name	Montano
Practitioner's First Name	Daniel
Practitioner's Middle Name	
Practitioner's Other Name (maiden, etc.)	
Gender	Male
Social Security	770287474
Tax ID (EIN)	844207450
Date of Birth	03 /07/1992
Correspondence Address Line 1	30350 SW 156th Ave
Address Line 2 (Unit #, Ste #, etc.)	
City	Homestead
State	FL
County	Miami-Dade
Zip Code	33033-3530
Email Address	julia@amromed.com
Confirm Email Address	julia@amromed.com
Web Address	
Phone Numbers (Include area code)	
Telephone #	786-283-0175
Fax #	305-847-0184
Requesting Individual (if submitting on behalf of the provider)	
Name	Julia Anderson
Title	Credentialing Specialist
Telephone #	909-575-1027
Email	julia@amromed.com
Race	
Ethnicity	

Expertise

Highest Degree Of Licensure	Behavioral Analyst		
Are you a APNs and/or PAs?	No		
For APNs and PAs only: I affirm I have a Collaborative Agreement with a supervising physician	False		
Population Treated	% of Practice	Are you accepting new patients?	
	Child (0-5)	20	True
	Child (6-12)	20	True
	Adolescent (13-17)	20	True
	Adult (18-64)	20	True
	Geriatric (65+)	20	True
Total Percent of Practice		100	
Practice Limitations	None		
Modalities Treated	% of Practice		
	Inpatient		
	Day Treatment		
	Outpatient	100	
	Intensive Outpatient (facility based)		
Total % of Practice		100	
Are you interested in becoming a Military OneSource Provider?	No		
Are you interested in becoming an EAP Provider?	No		
Languages	English		
Other Language			

Clinical Specialties	APPLIED BEHAVIOR ANALYST
Therapeutic Modalities	BEHAVIOR MODIFICATION THERAPY
Indicated Specialties	
Independent Licensure	
10-20 hours of documented training (continued education, etc) in past 1-2 years (and/or internship or post- doctoral fellowship in specialty)	
200 hours of direct clinical contact in past 5 years	
Access to (check one or all of the following)	
Supervision with a professional in the field	
Supervision with a peer supervision group	
Access to a prescribing provider (network or out-of-network)	
What percentage of your practice involves eating disorders?	
Are you a member of a state or national Eating Disorders provider network?	
If so, please indicate which organization(s)	
Are you prepared to do the necessary collateral work required for this population? (Work with this population requires coordination and collaboration with client's medical provider, dietician, family therapist, etc.)	
Do you have 2 years of EAP experience or 6 CEU's of SUD training?	

Locations

Site Name	My Little Hungry Caterpillar LLC		
Corporate or d/b/a Name (if different than Site Name)			
Solo NPI	1033759592		
Site Tax ID	844207450		
Practice Address			
Address	30350 SW 156th Ave		
Address 2			
City	Homestead		
County	Miami-Dade		
State	FL		
Zip Code	33033-3530		
Billing Address			
Billing address same as practice address	True		
Address	30350 SW 156th Ave		
Address 2			
City	Homestead		
County	Miami-Dade		
State	FL		
Zip Code	33033-3530		
Office Hours	Open	Close	
	Monday	08:00 am	06:00 pm
	Tuesday	08:00 am	06:00 pm
	Wednesday	08:00 am	06:00 pm
	Thursday	08:00 am	06:00 pm
	Friday	08:00 am	06:00 pm
	Saturday		
	Sunday		
Individual Medicaid #	110995800		
Group Medicaid #	0000271526		
Individual Medicare #	N/A		
Group Medicare #	N/A		
I affirm that Location is Accessible by Public Transportation	True		
I affirm that Location is Handicap Accessible	True		
I affirm that Location is ADA Compliant	True		
How can you be reached after hours?	Answering Service		
Name	Daniel Montano		
Phone #	786-283-0175		

Attachments

Attachment Name	W9 little.pdf
Attachment Size	245556 bytes
Document Type	W-9
Attachment Name	Resume.pdf
Attachment Size	267815 bytes
Document Type	Resume/CV

Attachment Name	PLI.pdf
Attachment Size	52587 bytes
Document Type	Malpractice Insurance
Expiration Date	

Attachment Name	Board.pdf
Attachment Size	1105596 bytes
Document Type	Board Certification
Expiration Date	

Attestations

I agree to the terms and conditions of the Specialty Attestation.	True
I, as a duly authorized representative of the practitioner or organization seeking network participation, have read and understand the Carelon Cultural Competency Training.	True
I agree to the terms and conditions of the Participant Attestation.	True
I agree to the terms and conditions of the Telehealth Attestation.	True

Final Attestation

I agree to all the attestations checked on the above and all terms and conditions of the Carelon Health Provider Program.	True
Full Name	Daniel Montano
Date	04/05/2024