Provider Data Form

Date:	Product: ❑MSCAN ❑MSCAN BH ❑Ambetter ❑Ambetter BH ❑Medicare Advantage ❑Medicare Advantage BH	Are you registered with CAQH? ❑Yes ❑No
If Yes, CAQH Provider ID:	Individual NPI:	
Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security #:	Medicaid ID #:	Medicare ID #:
Provider Type (MD, DO, PhD, LCSW, LPC, NP, etc.):	Are you a hospital based only provider not practicing in an office setting? ❑ Yes ❑ No	
***Primary Office Tax ID:	***Primary Office Group Billing NPI:	
Practice Name:	E-Mail Address:	
Primary Office Street Address:	Suite #:	
Primary Office City:	State:	County:	Zip:
Primary Telephone:	Primary Fax:	
Credentialing Contact Name:	Credentialing Contact Email:	Credentialing Contact Phone:
Primary Specialty:	Applying As: ❑ Specialist ❑ Primary Care Provider (e.g., Primary Care Physician, Mid- level provider)	
If PCP, are you accepting new patients? ❑ Yes ❑ No ❑ Yes, existing patients only	What gender or age restrictions do you have? Gender: ❑ No Restrictions ❑ Female Only ❑ Male Only Age: ❑ No Restrictions ❑ Age Limits: Lowest Age ____ Highest Age ____	
If PCP, please list maximum panel size (default is 1,500):		
Are you board certified? ❑ Yes ❑ No	If Yes, board name:	Exp. Date:
Please list any medical related organizations you have ownership with, e.g., laboratory, home health agency, radiology facility, mobile testing, MRI, etc.		
If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. **Attach a copy of your CLIA certificate or waiver if you have one.**		
Do you have a CLIA Certificate? ❑ Yes ❑ No	Do you have a CLIA waiver? ❑ Yes ❑ No	Type of Service Provided:
Certificate Number: _____ Certificate Expiration Date:	CLIA Name: _____ Tax ID #:	

*****If provider practices at more than one location, please include those additional locations on the following page (page 3).**