

New provider information data sheet

All fields with Asterix* are mandatory. Please complete this form in its entirety and use "N/A" if not applicable.

For new providers not needing credentialing

Provider Information		
*Group Name / Facility Name / Legal Name:		*Group Tax ID:
*Last Name:	*First Name:	Middle Initial:
*Provider's NPI:	*DOB:	*Provider Gender:
*Primary Specialty Taxonomy and Description:		*Secondary Specialty Taxonomy and Description:
*State License #: *Effective Date: *Term Date:	*DEA #: *Effective Date: *Term Date:	*Medicare Certified: <input type="checkbox"/> Yes CCN# _____ <input type="checkbox"/> No
*Is this provider a Primary Care Provider (PCP)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*Servicing Addresses: <i>If more than four offices, please attach roster of all locations. (Address, phone, fax, LOBs)</i>		
Address 1:	Applicable lines of business:	Does this provider perform
Phone: Fax:	<input type="checkbox"/> Medicaid <input type="checkbox"/> Marketplace <input type="checkbox"/> Duals <input type="checkbox"/> Medicare <input type="checkbox"/> CHP	PCP duties at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this location a FQHC? <input type="checkbox"/> Yes <input type="checkbox"/> No
Address 2:	Applicable lines of business:	Does this provider perform
Phone: Fax:	<input type="checkbox"/> Medicaid <input type="checkbox"/> Marketplace <input type="checkbox"/> Duals <input type="checkbox"/> Medicare <input type="checkbox"/> CHP	PCP duties at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this location a FQHC? <input type="checkbox"/> Yes <input type="checkbox"/> No
Address 3:	Applicable lines of business:	Does this provider perform
Phone: Fax:	<input type="checkbox"/> Medicaid <input type="checkbox"/> Marketplace <input type="checkbox"/> Duals <input type="checkbox"/> Medicare <input type="checkbox"/> CHP	PCP duties at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this location a FQHC? <input type="checkbox"/> Yes <input type="checkbox"/> No

Address 4 :	Applicable lines of business:	Does this provider perform
Phone: Fax:	<input type="checkbox"/> Medicaid <input type="checkbox"/> Marketplace <input type="checkbox"/> Duals <input type="checkbox"/> Medicare CHP	PCP duties at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this location a FQHC? <input type="checkbox"/> Yes <input type="checkbox"/> No
*Provider's Language(s) Spoken:	Accepting New Telehealth Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age Restriction <input type="checkbox"/> Yes From: To: <input type="checkbox"/> No
Medical Board-Certified Specialty <input type="checkbox"/> Yes Specialty: <input type="checkbox"/> No	Gender Restriction <input type="checkbox"/> Yes <input type="checkbox"/> No	*For mid-levels – Supervising physician name and NPI: