Provider Information Data Sheet

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

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: ☐Yes CCN#_____ ☐No
*Is this provider a Primary Care Provider (PCP)? ☐Yes ☐No		
*Servicing Addresses: *If more than four offices, please attach roster of all locations. (Address, phone, fax, LOBs)*		
Address 1: Phone: Fax:	Applicable lines of business: ☐Medicaid ☐Marketplace ☐Duals ☐Medicare ☐CHP	Does this provider perform PCP duties at this location? ☐Yes ☐No Is this location a FQHC? ☐Yes ☐ No
Address 2: Phone: Fax:	Applicable lines of business: ☐Medicaid ☐Marketplace ☐Duals ☐Medicare ☐CHP	Does this provider perform PCP duties at this location? ☐Yes ☐No Is this location a FQHC? ☐Yes ☐No
Address 3: Phone: Fax:	Applicable lines of business: ☐Medicaid ☐Marketplace ☐Duals ☐Medicare ☐CHP	Does this provider perform PCP duties at this location? ☐Yes ☐No Is this location a FQHC? ☐Yes ☐ No

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