Practitioner Data Form

Instructions:

- Please complete all information on this Practitioner Data Form in its entirety for each participating Practitioner in your group/practice. If needed, attach additional pages.
- Please be sure to include the Medicaid ID number(s).
- Please submit a copy of the Provider's W-9 (one per tax entity).
- Please submit a Disclosure of Ownership (DOO) form.
- Please submit current copy of general liability insurance form (certificate must include service location address(es) where services will be rendered).
- Please submit additional Medicaid forms, as applicable, including the LTSS Addendum and Behavioral Health Addendum forms.
- All practitioners must enroll with CAQH's Provider Data Portal (PDP) (formerly known as CAQH ProView). You must sign and date the CAQH Authorization, Attestation and Release (AAR) form every 120 days and give access to Centene Corporation (PO ID 240).

  If you have any questions, review CAQH's CAQH User Guide and Quick Reference Guide.

  Disability Access Definitions:

- Parking (P): Parking spaces, including van-accessible space(s), are accessible. Pathways have curb ramps between the parking lot, office and at drop-off locations.
- Exterior Building (EB): There is an accessible ramp to the building. Curb ramps and other ramps to the building are wide enough for a wheelchair/scooter. Handrails are provided on both sides of the ramp. Doors are wide enough to allow entrance for a wheelchair/scooter and the doors have handles that are easily opened
- Interior Building (IB): Doors are wide enough for a wheelchair/scooter and have handles that are easily opened. There are interior ramps available, and the ramps have handrails. If an elevator is present, it must be available for use by the public and members. The elevator has easy-to-hear sounds and Braille buttons within reach. The elevator is large enough for a wheelchair/scooter to turn around. If a chair lift is present, it can be utilized without help.
- Programmatic Access (PA): Programmatic access includes but is not limited to: methods of communicating with member for the provision of individual medical information and general health information; appointment scheduling procedures and time slots; and system-wide coordination and flexibility to enable access.

Date Completed:	**Individual NPI:**	
Are you registered with CAQH? ☐**Yes** ☐**No**	**If yes, CAQH Provider ID:**	
Last Name:	**First Name:**	**Middle Initial:**
Date of Birth:	**Social Security #:**	**Medicaid ID No(s) (list all, including rendering and organizational/billing):**
Medicare #:	**Are you a hospital-based only practitioner not practicing in an office setting?** ☐**Yes** ☐**No**	
Title/Degree (MD, DO, NP, etc.):		

Practitioner Ethnicity*	**Practitioner Race***
☐**Hispanic or Latino**	☐**American Indian** ☐**Asian** ☐**Native Hawaiian**
☐**Not Hispanic or Latino**	☐**Alaska Native** ☐**Other Pacific Islander** ☐**White**
	☐**Black or African American**

Has Practitioner completed Cultural Competency Training? ☐**Yes** ☐**No**

If Yes, did the Cultural Competency training include the following?

African American ☐**Yes** ☐**No** **Asian** ☐**Yes** ☐**No** **Alaskan Native** ☐**Yes** ☐**No**
American Indian ☐**Yes** ☐**No** **Hispanic/Latino** ☐**Yes** ☐**No** **Pacific Islander** ☐**Yes** ☐**No**
Other ☐**Yes** ☐**No**

License Number:	**License State:**	**Exp. Date:**
Are you board certified? ☐**Yes** ☐**No**	**If yes, board name:**	**Exp. Date:**

**This information is voluntary and will not be used for any discriminatory purpose.*

Billing Information:

Pay to Name (Issue Check to): Note: May be different than the name on the 1099.		
Pay to Address (Send remittance to):	**City State, Zip:**	**Phone Number:**
Billing Contact Name:	**Billing Contact Email:**	**Fax Number:**

Location Information 1 of ____

Location Name:	**Group NPI:**	**Tax ID No.:**
Location Street Address:	**Location City/State:**	**Location Zip Code:**
Location County:	**Primary Phone:**	**Primary Fax:**
Email Address:	**Website URL: (www.)**	

Credentialing Contact Information (Name, Address, E-mail):

Applying as: ☐ **Specialist** ☐ **Primary Care Provider (e.g., Primary Care Physician, Mid-Level Provider, etc.)**

Primary Specialty:	**Taxonomy:**	**Display in Online Directory (Find-A-Provider?)** ☐ **Yes** ☐ **No**	**Languages Spoken by Office:** **Language Services Available (Check One)** ☐ **Bilingual staff /interpreters/translation services and/or American sign language available** ☐ **No language services available**

Office Hours	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

☐ **24 Hours** ☐ **8 – 5 Monday - Friday**

PCP Panel: ☐ **Accepting New Patients** ☐ **Accepting Existing Only**	**Gender or Age restrictions?** **Gender:** ☐ **None** ☐ **Female Only** ☐ **Male Only** **Age:** ☐ **None** ☐ **Age Limits: Lowest Age ____ Highest Age ____**

Hospital Services Offered (Check all that apply). ☐ **Emergency Setting** ☐ **Post Stabilization Services**

Disability Access? (Check all that apply). Are you in compliance with Centene's minimum standard of disability access related to Parking, Exterior and Interior Building, and Programmatic access? For a list of minimum standards, contact 1-855-688-6589. If you check "Yes", you certify you meet **all** of the minimum standards.

Parking ☐ **Yes** ☐ **No** **Exterior Building** ☐ **Yes** ☐ **No**
Interior Building ☐ **Yes** ☐ **No** **Programmatic Access** ☐ **Yes** ☐ **No**

Does this location provide Laboratory Services? ☐ **Yes** ☐ **No** **If Yes, what is the CLIA # ID?**

Does this location provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for members under 21? ☐ **Yes** ☐ **No**

Does this location provide Patient Centered Medical Home? ☐ **Yes** ☐ **No**

Location Information 2 of ____

Location Name:	**Group NPI:**	**Tax ID No.:**
Location Street Address:	**Location City/State:**	**Location Zip Code:**
Location County:	**Primary Phone:**	**Primary Fax:**
Email Address:	**Website URL: (www.)**	

Credentialing Contact Information (Name, Address, E-mail):

Applying as: ☐ **Specialist** ☐ **Primary Care Provider (e.g., Primary Care Physician, Mid-Level Provider, etc.)**

Primary Specialty:	**Taxonomy:**	**Display in Online Directory (Find-A-Provider?)** ☐ **Yes** ☐ **No**	**Languages Spoken by Office:** **Language Services Available (Check One)** ☐ **Bilingual staff or interpreters and/or American sign language available** ☐ **No language services available**

Office Hours	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

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PCP Panel: ☐ **Accepting New Patients** ☐ **Accepting Existing Only**	**Gender or Age restrictions?** **Gender:** ☐ **None** ☐ **Female Only** ☐ **Male Only** **Age:** ☐ **None** ☐ **Age Limits: Lowest Age ____ Highest Age ____**

Hospital Services Offered (Check all that apply). ☐ **Emergency Setting** ☐ **Post Stabilization Services**

Disability Access? (Check all that apply). Are you in compliance with Centene's minimum standard of disability access related to Parking, Exterior and Interior Building, and Programmatic access? For a list of minimum standards, contact 1-855-688-6589. If you check "Yes", you certify you meet **all** of the minimum standards.

Parking ☐ **Yes** ☐ **No** **Exterior Building** ☐ **Yes** ☐ **No**

Interior Building ☐ **Yes** ☐ **No** **Programmatic Access** ☐ **Yes** ☐ **No**

Does this location provide Laboratory Services? ☐ **Yes** ☐ **No** **If Yes, what is the CLIA # ID?**

Does this location provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for members under 21? ☐ **Yes** ☐ **No**

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