Practitioner Data Form

Instructions:

- Information on this Data Form must be provided and completed in its entirety for each Practitioner seeing patients within the Group or Facility.
- Please submit a copy of the Provider's W-9 (one per tax entity).
- Please make copies and attach additional Location Information pages, if necessary.
- Please ensure to include the Medicaid ID number.
- Please attach the Ownership and Disclosure Form.
- If a Practitioner participates with CAQH, you may optionally provide this information and allow Centene Corporation access to your application information. (Attested within 120 days)
- Behavioral Health Providers must complete Behavioral Health Addendum.

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 (11 digits):**
Medicare #		
Title/Degree (MD, DO, PhD, LCSW, LPC, NP, etc.):		
Has Provider completed Cultural Competency Training? ☐ **Yes** ☐ **No**		
If Yes, did the training include the following? **African American** ☐**Yes** ☐ **No** **Asian** ☐**Yes** ☐ **No** **Alaskan Native** ☐**Yes** ☐ **No** **Hispanic/Latino** ☐**Yes** ☐ **No** **American Indian** ☐**Yes** ☐ **No** **Pacific Islander** ☐**Yes** ☐ **No** **Other_____** ☐**Yes** ☐ **No**		

Billing Information (Complete this section if different than the W9):

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:**
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 Find-A-Provider?** **☐ Yes ☐ No**	**Languages Spoken (including American Sign Language):**

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

☐ 24 Hours ☐ 8 – 5 Monday - Friday

License Number:	**License State:**	**Exp. Date:**
Are you board certified? **☐ Yes ☐ No**	**If yes, board name:**	**Exp. Date:**
If PCP, are you accepting new patients? ☐ Yes ☐ No **☐ Yes, existing patients only**	**Gender or Age restrictions?** **Gender: ☐ None ☐ Female Only ☐ Male Only** **Age: ☐ None ☐ Age Limits: Lowest Age ____ Highest Age ____**	

Are the following areas in your office ADA Compliant? (Check all that apply)
☐ Building ☐ Bathroom(s) ☐ Therapy Room(s) ☐ Parking ☐ Equipment

Location Information _____ of _____

Location Name:	**Group NPI:**	**Tax ID:**
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.)

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