

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: <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: Phone: Fax:	Applicable lines of business: <input type="checkbox"/> Medicaid <input type="checkbox"/> Marketplace <input type="checkbox"/> Duals <input type="checkbox"/> Medicare <input type="checkbox"/> CHP	Does this provider perform 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: