

Practitioner Data Form

Instructions:

- Information on this Data Form must be provided in its entirety for each participating Practitioner.
- Please submit a copy of the Provider's W-9 (one per tax entity).
- If needed, attach additional pages.
- Please be sure to include the Medicaid ID number.
- 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)

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.

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| Date Completed: | | Individual NPI: | |
| Are you registered with CAQH? <input type="checkbox"/> Yes <input type="checkbox"/> No | | If yes, CAQH Provider ID: | |
| Last Name: | | First Name: | Middle Initial: |
| Date of Birth: | | Social Security #: | Medicaid ID: |
| Medicare #: | | Are you a hospital-based only practitioner not practicing in an office setting? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Title/Degree (MD, DO, NP, etc.): | | | |
| Has Practitioner completed Cultural Competency Training? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If Yes, did the training include the following? African American <input type="checkbox"/> Yes <input type="checkbox"/> No Asian <input type="checkbox"/> Yes <input type="checkbox"/> No Alaskan Native <input type="checkbox"/> Yes <input type="checkbox"/> No Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No American Indian <input type="checkbox"/> Yes <input type="checkbox"/> No Pacific Islander <input type="checkbox"/> Yes <input type="checkbox"/> No Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| License Number: | | License State: | Exp. Date: |
| Are you board certified? <input type="checkbox"/> Yes <input type="checkbox"/> No | | If yes, board name: | Exp. Date: |

Billing Information:

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| 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: |

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| 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: <input type="checkbox"/> Specialist <input type="checkbox"/> Primary Care Provider (e.g., Primary Care Physician, Mid-Level Provider, etc.) | | | | | | | |
| Primary Specialty: | | Taxonomy: | | Display in Find-A-Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Languages Spoken (including American Sign Language): | |
| Office Hours | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| <input type="checkbox"/> 24 Hours <input type="checkbox"/> 8 – 5 Monday - Friday | | | | | | | |
| If PCP, are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, existing patients only | | | Gender or Age restrictions? Gender: <input type="checkbox"/> None <input type="checkbox"/> Female Only <input type="checkbox"/> Male Only Age: <input type="checkbox"/> None <input type="checkbox"/> Age Limits: Lowest Age _____ Highest Age _____ | | | | |
| Hospital Services Offered (Check all that apply). <input type="checkbox"/> Emergency Setting <input type="checkbox"/> 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. | | | | | | | |
| Parking <input type="checkbox"/> Yes <input type="checkbox"/> No | | Exterior Building <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Interior Building <input type="checkbox"/> Yes <input type="checkbox"/> No | | Programmatic Access <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| If you check “Yes”, you certify you meet all of the minimum standards. | | | | | | | |
| Does this location provide Laboratory Services? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what is the CLIA #? ID _____ | | | | | | | |
| Does this location provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for members under 21? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| Does this location provide Patient Centered Medical Home? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |

Location Information 2 of _____

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| 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: <input type="checkbox"/> Specialist <input type="checkbox"/> Primary Care Provider (e.g., Primary Care Physician, Mid-Level Provider, etc.) | | | | | | | |
| Primary Specialty: | | Taxonomy: | Display in Find-A-Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Languages Spoken (including American Sign Language): | | |
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| <input type="checkbox"/> 24 Hours <input type="checkbox"/> 8 – 5 Monday - Friday | | | | | | | |
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| If you check “Yes”, you certify you meet all of the minimum standards. | | | | | | | |
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