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 Practitioner's W-9 (one per tax entity).
- If needed, attach additional pages.
- If participating with CAQH, please authorize access to Centene Corporation.
- CAQH must be recently 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.

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:**
Medicare #:	**Are you a hospital-based only provider not practicing in an office setting?** ☐ Yes ☐ No	
Title/Degree (MD, DO, PA, 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		
License Number:	**License State:**	**Exp. Date:**
Are you board certified? ☐ Yes ☐ No	**If yes, board name:**	**Exp. Date:**

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 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**

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 ____

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.
Parking   ☐ **Yes** ☐ **No**   **Exterior Building** ☐ **Yes** ☐ **No**
Interior Building ☐ **Yes** ☐ **No**   **Programmatic Access** ☐ **Yes** ☐ **No**
If you check "Yes", you certify you meet **all** of the minimum standards.

Does this location provide Laboratory Services? ☐ **Yes** ☐ **No**
If Yes, Accrediting/Certifying program (CLIA, COLA, MLE, etc.) ____ ID ____

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

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

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

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Parking   ☐ **Yes** ☐ **No**   **Exterior Building** ☐ **Yes** ☐ **No**
Interior Building ☐ **Yes** ☐ **No**   **Programmatic Access** ☐ **Yes** ☐ **No**
If you check "Yes", you certify you meet **all** of the minimum standards.

Does this location provide Laboratory Services? ☐ **Yes** ☐ **No**
If Yes, Accrediting/Certifying program (CLIA, COLA, MLE, etc.) ____ ID ____

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