



PROVIDER INFORMATION FORM

NEW APPLICANT INFORMATION										DATE: ___/___/___	
Last Name:				First:				M.I.	Degree:		
Group Practice Address:								Unit/Floor#			
City:		State:	ZIP+4:		Gender:	M <input type="checkbox"/>	F <input type="checkbox"/>	Race/Ethnicity:			
Phone: ()					Fax: ()						
Group Contact E-mail Address:											
CT State Medicaid #:			Social Security #:				Practice Tax ID:				
Name of Group:											
Group NPI #:					Group Taxonomy:						
Are you accepting new Patients?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	Are you accepting referrals for new patients?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	Do you wish to appear in provider directory?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you speak languages other than English?			YES <input type="checkbox"/>	NO <input type="checkbox"/>	If so, list languages:						
CREDENTIALING INFORMATION											
Specialties:						Provider Type:	PCP <input type="checkbox"/>	Specialist <input type="checkbox"/>	Allied Health <input type="checkbox"/>		
Are you board certified?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Board Name:								
Are you registered with CAQH?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If No, would you like us to register you?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	CAQH Provider ID:				
Individual NPI#:					Individual Taxonomy#:						
State license #:			Licensed State:				Expiration: ___/___/___				
DEA Certificate #:			DEA State:				Expiration: ___/___/___				
Credentialing Correspondence Address:											
City/State/Zip +4:						Credentialing Phone Number: ()					
Contact Name:				Credentialing Email Address:							
Hospital Admitting Privileges:		YES <input type="checkbox"/>	NO <input type="checkbox"/>	If so, list locations:							
IMPORTANT ADDITIONAL ADDRESS INFORMATION <small>PLEASE FILL OUT COMPLETELY</small>											
Population Served:						Limitations/Age Restrictions:					
Billing Address:											
City/State/Zip +4:						Telephone: ()					
						Fax: ()					
Additional Practice Location 2:											
City/State/Zip +4:						Telephone: ()					
Wheel Chair Access:						Fax: ()					
Additional Practice Location 3:											
City/State/Zip +4:						Telephone: ()					
Wheel Chair Access:						Fax: ()					

