

**COMMUNITY HEALTH NETWORK CAQH PROVIDER DATA FORM**

*For Credentialing Purposes*

\* = **Optional fields**

DATE:				
Last Name:		First Name:		Middle Initial:
Date of Birth:	Primary Practice Telephone:		* Primary Practice email:	
Primary Practice Name:				
Primary Practice Street Address:				Suite #:
Primary Office City:		State:	County:	Zip:
Provider Type (MD, DO, DC, DDS, DMD, DPM):				
Specialty:		Applying As: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Allied Health Professional		
Are you board certified? Yes      No		If Yes, board name:		
Are you registered with CAQH? Yes      No		If Yes, CAQH Provider ID:		
Primary Fax No.:		*Credentialing Email Address:		
Social Security No.:		DEA Certificate No.:		
State License No.:		Licensed State:		
NPI # :		Practice Tax ID:		
Taxonomy #		Contact name:		
Credentialing correspondence address:		Please list additional practice sites below (if applicable)		

**Lines of Business:** HUSKY \_\_\_\_\_ CHARTER OAK \_\_\_\_\_ SAGA \_\_\_\_\_ ( PLACE X for Yes)

Note: If you have already completed your application with CAQH, please ensure that you have authorized all applicable organizations to access your data. Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with any of the above organizations. If applicable, please contact the health plan directly to request contracting information.