



Provider Data Form

Date:	Product: <input type="checkbox"/> MSCAN <input type="checkbox"/> Ambetter <input type="checkbox"/> Medicare Advantage	Are you registered with CAQH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, CAQH Provider ID:		Individual NPI:	
Last Name:		First Name:	Middle Initial:
Date of Birth:	Social Security #:	Medicaid ID #:	
Provider Type (MD, DO, PhD, LCSW, LPC, NP, etc.):		Are you a hospital based only provider not practicing in an office setting? <input type="checkbox"/> Yes <input type="checkbox"/> No	
***Primary Office Tax ID:		***Primary Office Group Billing NPI:	
Practice Name:		E-Mail Address:	
Primary Office Street Address:			Suite #:
Primary Office City:		State:	County: Zip:
Primary Telephone:		Primary Fax:	
Credentialing Contact Name:	Credentialing Contact Email:	Credentialing Contact Phone:	
Primary Specialty:		Applying As: <input type="checkbox"/> Specialist <input type="checkbox"/> Primary Care Provider (e.g., Primary Care Physician, Mid-level provider)	
If PCP, are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, existing patients only		What gender or age restrictions do you have? Gender: <input type="checkbox"/> No Restrictions <input type="checkbox"/> Female Only <input type="checkbox"/> Male Only Age: <input type="checkbox"/> No Restrictions <input type="checkbox"/> Age Limits: Lowest Age ____ Highest Age ____	
If PCP, please list maximum panel size (default is 1,500):			
Are you board certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, board name:		Exp. Date:
Please list any medical related organizations you have ownership with, e.g., laboratory, home health agency, radiology facility, mobile testing, MRI, etc.			
If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.			
Do you have a CLIA Certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a CLIA waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Service Provided:	
Certificate Number: Certificate Expiration Date:		CLIA Name: Tax ID #:	

***If provider practices at more than one location, please include those additional locations on the following page (page 2).

Note: If you have already completed your application with CAQH, please ensure that you have authorized Magnolia Health to access your data. This can be done by calling CAQH at (888) 599-1771 or by logging into your account and adding Magnolia Health to your list of authorized plans. Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with Magnolia Health.

Additional Practice Locations

Complete the section below if the provider practices at more than one location. Please make additional copies of this page if necessary.

① Location Name	Tax ID Number
Group NPI Number	Group Medicaid ID Number
Street Address	City, State, Zip Code
Billing Address, if different from Page 1	City, State, Zip Code
Location Point of Contact	Phone Number
Fax Number	E-mail Address

② Location Name	Tax ID Number
Street Address	City, State, Zip Code
Group NPI Number	Group Medicaid ID Number
Billing Address, if different from Page 1	City, State, Zip
Location Point of Contact	Phone Number
Fax Number	E-mail Address

③ Location Name	Tax ID Number
Street Address	City, State, Zip
Group NPI Number	Group Medicaid ID Number
Billing Address, if different from Page 1	City, State, Zip
Location Point of Contact	Phone Number
Fax Number	E-mail Address