magnolia health

Provider Data Form

Provider Credentialing / Enrollment (Ambetter and Wellcare)
Provider Enrollment (MSCAN and CHIP)

If this request is for MSCAN only, please complete the unhighlighted cells of Provider Data Form only

If provider practices at more than one location, please include those additional locations on the following pages

If you are enrolling for all lines of business, please review the instructions on the Magnolia Credentialing Application Packet

Date:	Product: ❑MSCAN ❑MSCAN BH ❑CHIP ❑CHIP BH ❑Ambetter ❑Ambetter BH ❑Medicare Advantage ❑Medicare Advantage BH	Are you registered with CAQH? ❑Yes ❑No

If Yes, CAQH Provider ID:		Individual NPI:	
Last Name:	First Name:		Middle Initial:
Date of Birth:	Social Security #:	Medicaid ID #:	Medicare ID #:
Provider Type (MD, DO, PhD, LCSW, LPC, NP, etc.):		Primary Specialty (Taxonomy):	
***Primary Office Tax ID:		***Primary Office Group Billing NPI:	
Group Billing Taxonomy		Practice Name:	
E-Mail Address:		Practice Website:	
Primary Office Street Address:			Suite #:
Primary Office City:	State:	County:	Zip:
Primary Telephone:		Primary Fax:	
Credentialing Contact Name:	Credentialing Contact Email:		Credentialing Contact Phone:

Are you a hospital based only provider not practicing in an office setting?❑ Yes ❑ No	Applying As: ❑ Specialist ❑ Primary Care Provider (e.g., Primary Care Physician, Mid- level provider)
If PCP, are you accepting new patients? ❑ Yes ❑ No ❑ Yes, existing patients only	What gender or age restrictions do you have? Gender: ❑ No Restrictions ❑ Female Only ❑ Male Only Age: ❑ No Restrictions ❑ Age Limits: Lowest Age _____ Highest Age
If PCP, please list maximum panel size (default is 1,500):	

Are you board certified? ❑ Yes ❑ 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? ❑ Yes ❑ No	Do you have a CLIA waiver? ❑ Yes ❑ No	Type of Service Provided:
Certificate Number:		CLIA Name:
Certificate Expiration Date:		Tax ID #:

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.

*****If provider practices at more than one location, please include those additional locations on the following pages.**

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.

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

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