



magnolia health[™] Provider Data Form

Date:	Product: <input type="checkbox"/> MSCAN <input type="checkbox"/> Ambetter <input type="checkbox"/> CHIP <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 3).