Provider Data Form

Date:	Product: ❑ MSCAN ❑ Ambetter ❑ Medicare Advantage	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 #:
Provider Type (MD, DO, PhD, LCSW, LPC, NP, etc.):	Are you a hospital based only provider not practicing in an office setting? ❑ Yes ❑ 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: ❑ 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: 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.

①Location 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**

②Location 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**