CAQH PROVIDER DATA FORM

For Credentialing Purposes

USE THIS FORM TO ENROLL A MEDICAL PRACTITIONER ONLY

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Date:			Are you registered with CAQH (requirement)? ☐ Yes ☐ No
If Yes, CAQH Provider ID:			Social Security:
Last Name:	First Name:		Middle Initial:
Date of Birth:	Individual NPI:		Medicaid ID #:
Medicare ID #:	Provider Type (MD, DO, PhD, etc.):		
Are you a hospital based only provider not practicing in an office setting? ☐ Yes ☐ No	Telehealth? ☐ Yes ☐ No		Tax ID:
Practice Name:			Email Address:
Primary Office Street Address:			Suite #:
Primary Office City:	State:	County:	Zip:
Primary Telephone:			Primary Fax:
Group NPI(s):			
Secondary Office Street Address:			Suite #:
Secondary Office City:	State:	County:	Zip:
Secondary Telephone:			Secondary Fax:
Group NPI(s):			
Covering Location #1* Street Address:			Suite #:
Covering Location #1 City:	State:	County:	Zip:
Covering Location #1 Telephone:			Covering Location #1 Fax:
Group NPI(s):			
Covering Location #2* Street Address:			Suite #:
Covering Location #2 City:	State:	County:	Zip:
Covering Location #2 Telephone:			Covering Location #2 Fax:
Group NPI(s):			
Covering Location #3* Street Address:			Suite #:
Covering Location #3 City:	State:	County:	Zip:
Covering Location #3 Telephone:			Covering Location #3 Fax:
Group NPI(s):			

** If you have more than three covering locations please use a copy of this form to add the additional locations only. You do not have to complete the other fields again.*

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Credentialing Contact Information:			
Applying As: ☐ Specialist ☐ Primary Care Physician		PCP Panel: ☐ Open Panel ☐ Closed Panel ☐ Accepting Existing Patients	
Primary Specialty:	*Practitioners Taxonomy:	Secondary Specialty:	*Practitioners Taxonomy:
Please list any patient age restrictions:		Gender Limitations: ☐ Male Only ☐ Female Only	
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 healthy 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 #:	

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

*Practitioners taxonomies listed must match the taxonomies listed on NPPES and CAQH provider report.