CAQH Provider Data Form

For Credentialing Purposes

USE THIS FORM TO ENROLL A MEDICAL PRACTITIONER ONLY

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:	Medicare ID #:	
Medicaid ID #:	Provider Type (MD, DO, PhD, etc.):		
Practitioners License #:		Expiration Date:	
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):			
Hours of Operation:			
Secondary Office Street Address:			Suite #:
Secondary Office City:	State:	County:	Zip:
Secondary Telephone:		Secondary Fax:	
Group NPI(s):			
Hours of Operation:			
Covering Location #1* Street Address:			Suite #:
Covering Location #1 City:	State:	County:	Zip:
Covering Location #1 Telephone:		Covering Location #1 Fax:	
Group NPI(s):			
Hours of Operation:			

** 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.*

Continued on other side ➲

CAQH Provider Data Form *(continued)*

Covering Location #2* Street Address: Suite #:

Covering Location #2 City: State: County: Zip:

Covering Location #2 Telephone: Covering Location #2 Fax:

Group NPI(s):

Hours of Operation:

Covering Location #3* Street Address: Suite #:

Covering Location #3 City: State: County: Zip:

Covering Location #3 Telephone: Covering Location #3 Fax:

Group NPI(s):

Hours of Operation:

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? If Yes, board name: Expiration Date:
☐ Yes ☐ No

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: CLIA Name:

Certificate Expiration Date: 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.