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PROVIDER DEMOGRAPHIC FORM

*Please make sure to complete this form with all types of requests such as adding a new provider, location update, terminating a provider, any type of update. This form is required in order for any changes to be processed.

Group/Facility Name: _____

Group/Facility Specialty: _____

Tax ID: _____ Group NPI: _____ Group TPI: _____

Select Program: ☐ Medicaid ☐ CHIP/Perinatal ☐ STAR Plus ☐ Preferred Administrators ☐ HCO ☐ Medicare

☐ PCP ☐ Specialist ☐ PCP/Specialist ☐ Hospital Based ☐ Home Health/DME ☐ PAS ☐ SNF ☐ Other

Include Provider Specialty: Specialty: _____ Subspecialty: _____

Last, First, M Name: _____ DOB: _____ SS#: _____

Individual NPI: _____ API: _____ TPI: _____

CAQH: _____ Medicare #: _____ LTSS X Code: _____

Professional Category: ☐ MD ☐ DO ☐ FNP ☐ ACNP ☐ PA ☐ CRNA ☐ Other: _____

Taxonomy number(s): _____

***If provider is not enrolled with CAQH, please provide a TDI Credentialing application w/current date and signature.**

Primary Practice Address: _____

City, State, ZIP: _____ Office Hours/Days: _____

Phone: _____ Fax: _____ Website URL: _____

CLIA Number: _____ CLIA Type: _____

***Please provide CLIA numbers for each location.**

Secondary Location: _____ City, State, ZIP: _____

Office Hours/Days: _____ Phone: _____ Fax: _____

CLIA Number: _____ CLIA Type: _____

Third Location: _____ City, State, ZIP: _____

Office Hours/Days: _____ Phone: _____ Fax: _____

CLIA Number: _____ CLIA Type: _____

Fourth Location: _____ City, State, ZIP: _____

Office Hours/Days: _____ Phone: _____ Fax: _____

CLIA Number: _____ CLIA Type: _____

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PROVIDER DEMOGRAPHIC FORM

Languages Spoken: ☐ English ☐ Spanish ☐ American Sign Language (ASL) ☐ Other:_____

Accepting New Patients: ☐ Yes ☐ No ☐ Established Only ☐ Age Range: _____

Practice Limitations: ☐ Male only ☐ Female Only ☐ None ☐ Other:_____

Radiology Certificate: ☐ Yes ☐ No Completed cultural diversity training? ☐ Yes ☐ No

Do you offer: ☐ Telemedicine ☐ Telehealth ☐ Telemonitoring ☐ Targeted Case Management

Does this office meet American Disabilities Act (ADA) accessibility requirements? ☐ Yes ☐ No

Billing Information (**Must Reflect W-9**):_____

Doing Business As:_____

Pay to Address:_____ Tax ID:_____

Primary Contact:_____ **Primary Contact Address:** _____

Phone:_____ **Email:**_____

***In order to not delay the credentialing process, please provide all credentialing contact information.**

Reason for submission:_____

Completed by: _____

FOR OFFICE USE ONLY: ☐ New Load ☐ Update ☐ Term **Effective Date**:_____

Provider Type Code:_____ Provider Specialty Code(s):_____ LTSS X Code:_____

Products: ☐ STAR w/TPI ☐ STAR w/o TPI ☐ CHIP/PERINATE ☐ STAR+PLUS ☐ TPA ☐ HCO ☐ MEDICARE

Contract Type: ☐ Individual ☐ Group ☐ Ancillary/Facility ☐ Amendment ☐ LOA ☐ Par ☐ Non-Par

Comments:_____

_____

_____

_____

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