pa health & wellness

Practitioner Data Form

Instructions: This Practitioner Data Form must be completed in its entirety. If needed, attach additional pages for location information. Email completed form to PHWProviderData@PaHealthWellness.com

Application Date:	**Are you registered with CAQH?** ☐ Yes ☐ No *(Remember to attest to ensure Centene Corp is authorized to access your data)*	
Individual NPI:	**If yes, CAQH Provider ID:**	
Last Name:	**First Name:**	**Middle Initial:**
Date of Birth:	**Social Security #:**	**PROMISe ID #:**
Gender:	**Race/Ethnicity:**	
Provider Type (MD, DO, PhD, LCSW, LPC, NP, etc):	**Are you a Hospital-based only provider not practicing in an office setting?** ☐Yes ☐ No	

Location Information 1 of ____ **Provider PROMISe ID #:**________________________________

Location Name:	**Group NPI:**	**Tax ID:**
Location Street Address:	**Location City/State:**	**Location Zip Code:**
Location County:	**Primary Phone:**	**Primary Fax:**
Email Address:		
Credentialing Contact Information (Name, Address, E-mail):		
Applying as: ☐ Specialist ☐ Primary Care Provider	**Primary Specialty:**	**Taxonomy:**

Secondary Specialty:	**Taxonomy:**	**Display in Find-A-Provider?** ☐ Yes ☐ No	**Languages Spoken:**

Office Hours	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

☐ **24 Hours** | ☐ **8 – 5 Monday – Friday** **Do You Provide Telehealth Service?** ☐ Yes ☐ No

License Number:	**License State:**	**Exp. Date:**
Are you board certified? ☐Yes ☐ No	**If yes, board name:**	**Exp. Date:**

Do you have Hospital Privileges or Admitting Arrangements? **(REQUIRED for NP & PA)** ☐Yes ☐ No

A copy of the Hospital Privileges or Admitting Arrangements **must** be returned with this form. If No, a copy of the admitting procedures **must** be attached or enrollment/credentialing cannot be completed.

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 #:**
If PCP, are you accepting new patients? ☐Yes ☐ No	**Gender or Age restrictions?** **Gender:** ☐ None ☐ Female Only ☐ Male Only **Age:** ☐ None ☐ Age Limits: Lowest Age ___ Highest Age ___

Location Information 2 of ___ **Provider PROMISe ID #: ________________________________**

Location Name:	**Group NPI:**	**Tax ID:**
Location Street Address:	**Location City/State:**	**Location Zip Code:**
Location County:	**Primary Phone:**	**Primary Fax:**

Email Address:

Credentialing Contact Information (Name, Address, E-mail):

Applying as: ☐ Specialist ☐ Primary Care Provider	**Primary Specialty:**	**Taxonomy:**

Secondary Specialty:	**Taxonomy:**	**Display in Find-A-Provider?** ☐ Yes ☐ No	**Languages Spoken:**

Office Hours	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

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License Number:	**License State:**	**Exp. Date:**
Are you board certified? ☐Yes ☐ No	**If yes, board name:**	**Exp. Date:**

Do you have Hospital Privileges or Admitting Arrangements? **(REQUIRED for NP & PA)** ☐Yes ☐ No

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Certificate Number:	**CLIA Name:**
Certificate Expiration Date:	**Tax ID #:**

If PCP, are you accepting new patients? ☐Yes ☐ No	**Gender or Age restrictions?** **Gender:** ☐ None ☐ Female Only ☐ Male Only **Age:** ☐ None ☐ Age Limits: Lowest Age ___ Highest Age ___

Location Information 3 of ___ **Provider PROMISe ID #: ________________________________**

Location Name:	Group NPI:	Tax ID:
Location Street Address:	**Location City/State:**	**Location Zip Code:**
Location County:	**Primary Phone:**	**Primary Fax:**

Email Address:
Credentialing Contact Information (Name, Address, E-mail):

Applying as: ☐ Specialist ☐ Primary Care Provider	**Primary Specialty:**	**Taxonomy:**

Secondary Specialty:	**Taxonomy:**	**Display in Find-A-Provider?** ☐ Yes ☐ No	**Languages Spoken:**

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☐ **24 Hours | ☐ 8 – 5 Monday – Friday** **Do You Provide Telehealth Service?** ☐ Yes ☐ No

License Number:	**License State:**	**Exp. Date:**
Are you board certified? ☐Yes ☐ No	**If yes, board name:**	**Exp. Date:**

Do you have Hospital Privileges or Admitting Arrangements? (REQUIRED for NP & PA) ☐Yes ☐ No

A copy of the Hospital Privileges or Admitting Arrangements **must** be returned with this form. If No, a copy of the admitting procedures **must** be attached or enrollment/credentialing cannot be completed.

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Certificate Number:	**CLIA Name:**
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If PCP, are you accepting new patients? ☐Yes ☐ No	**Gender or Age restrictions?** **Gender:** ☐ None ☐ Female Only ☐ Male Only **Age:** ☐ None ☐ Age Limits: Lowest Age ___ Highest Age ___