



## PROVIDER DATA FORM

Date:	Please indicate if you provide the below service(s): <input type="checkbox"/> Telehealth <input type="checkbox"/> Telemedicine <input type="checkbox"/> Telemonitoring	Are you registered with CAQH? <input type="checkbox"/> Yes <input type="checkbox"/> 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, etc.):		Are you a hospital based only provider not practicing in an office setting? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Tax ID:		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 Information (Name, Address, E-Mail):			Primary Specialty:	
Office Hours : Monday <input type="checkbox"/> _____ to _____    Friday <input type="checkbox"/> _____ to _____ Tuesday <input type="checkbox"/> _____ to _____    Saturday <input type="checkbox"/> _____ to _____ Wednesday <input type="checkbox"/> _____ to _____    Sunday <input type="checkbox"/> _____ to _____ Thursday <input type="checkbox"/> _____ to _____		Applying As: <input type="checkbox"/> Specialist  <input type="checkbox"/> Primary Care Provider (e.g., Primary Care Physician, Mid- level provider)		
If PCP, are you accepting new patients?  <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes, existing patients only		What gender or age restrictions do you have?  Gender: <input type="checkbox"/> No Restrictions <input type="checkbox"/> Female Only <input type="checkbox"/> Male Only  Age: <input type="checkbox"/> No Restrictions <input type="checkbox"/> Age Limits: Lowest Age _____ Highest Age _____		
License Number:	License State:		Exp. Date:	
Are you board certified? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a CLIA waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Service Provided:		
Certificate Number: Certificate Expiration Date:			C LI A	
Secondary Office Street Address: (include any additional locations on a separate page)				Suite #:
Secondary Office City:			State:	County:    Zip:
Secondary Telephone:			Secondary Fax:	

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