

# Provider Data Form



Group Name:		Tax ID:	Provider Gender (M or F):					
Provider Last Name:		Provider First Name:			Provider Middle Initial:			
CAQH Provider ID:		Individual NPI:			Group NPI:			
Primary Specialty:		Additional Specialty:			Taxonomy Code:			
Board certified? Yes No		Name of Board:			Exp Date of Board:			
Provider Ethnicity + Race:		Individual FL Medicaid ID:		Gender Accepted:				
Group FL Medicaid ID:		FL Medical License Number:			Age Range:			
Provider Type (MD, DO, PhD, LCSW, LPC, etc.):		Languages Spoken:			Applying As: PCP or Specialist:			
Hospital Affiliations (Yes/No):		If Yes, Name of Hospital:						
Group Website URL:		EMR (Yes/No):			Name of EMR:			
Primary Office Street Address:		Suite #:			Primary Office City:			
Primary Office State:		Primary Office Zip Code:			Primary Phone:			
Primary Fax:		Wheelchair Access (Yes/No):			Is there a Medical Interpreter on Site:			
Contact Name:	Contact Phone Number:	Office Hours:						
		Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Contact Email:								
Billing Street Address:		Suite #:						
Billing City:		Billing State:			Billing Zip Code:			
Billing Phone:		Billing Fax:			Appear in Directory (Yes/No):			

**\*For additional Service Locations please list on page 2, including Phone, Fax, Office Hours and Handicap Accessibility.**

1 Please complete one form for each practitioner in the practice. For assistance, call 1-855-819-9506.

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## Additional Addresses

\*Circle the Address Type that Applies.

### **Additional Address is: (Primary, Mailing, Credentialing and/or Patient)**

Street Address:			Suite #:			
City:	State:	County:	Zip Code:			
Phone Number:	Fax Number:	Handicap Accessible (Yes/No)	Is there a Medical Interpreter on Site:			
Office Hours:						
Sun	Mon	Tues	Wed	Thurs	Fri	Sat

### **Additional Address is: (Primary, Mailing, Credentialing and/or Patient)**

Street Address:			Suite #:			
City:	State:	County:	Zip Code:			
Phone Number:	Fax Number:	Handicap Accessible (Yes/No)	Is there a Medical Interpreter on Site:			
Office Hours:						
Sun	Mon	Tues	Wed	Thurs	Fri	Sat

### **Additional Address is: (Primary, Mailing, Credentialing and/or Patient)**

Street Address:			Suite #:			
City:	State:	County:	Zip Code:			
Phone Number:	Fax Number:	Handicap Accessible (Yes/No)	Is there a Medical Interpreter on Site:			
Office Hours:						
Sun	Mon	Tues	Wed	Thurs	Fri	Sat