Provider Data Form

For Credentialing Purposes

To begin your credentialing process, please use this simple form. Please note that the top portion of this form is required information. If you are registered with CAQH Universal Credentialing DataSource, **please contact CAQH to authorize AgeWell New York access to provider's credentialing file.**

Date:	Date of Birth:	NPI #:		
Last Name:		First Name	Middle Initial	
Primary Phone No.:	Primary Fax No.:	Office E-Mail Address:		
Primary Practice Name:		Billing Tax ID No.: (**Attach W9**)	Group NPI No:	
Primary Office Street Address			Suite Number	
Primary Office City:	State:	County:	Zip Code:	
Billing Address (where payments go):		Billing City, State, Zip Code		
Provider Type: (MD, DO, DC, NP, DPM, DMD, PT, etc):		House Calls : ☐Yes ☐No		
Applying as: ☐PCP ☐SCP ☐PCP/SCP ☐Allied Health Professional ☐Hospitalist		**Panel Status (PCP Only):** ☐Open (Accepting new patients) ☐Existing Patients Only ☐Closed (Not accepting any patients) ☐Nursing Home Only (Limited to Nursing Homes)		
Primary Specialty:		Secondary Specialty:		
Are you board certified: ☐ Yes ☐ No		If Yes, board name:		
Are you registered with CAQH? ☐ Yes ☐ No		If Yes, CAQH Provider ID:		

Primary Office Hours:

Mon: _____ Tues: _____ Wed: _____ Thurs: _____ Fri: _____
Sat: _____ Sun: _____

Language spoken: _____ Handicapped Accessible: ☐Yes ☐No

Secondary Practice	Address:	City:
		State: Zip Code:
Secondary Billing	Address:	City:
	Tax ID:	State: Zip Code:

If you are not registered with CAQH, please provide the following additional information, which is necessary to register you with the CAQH Universal Credentialing DataSource.

Primary Fax No.:	E-Mail Address:
Social Security Number:	DEA Certificate No.:
State License No.:	Licensed State:
UPIN:	Tax ID:

FOR INTERNAL PURPOSES ONLY (Section 1 should be completed by Provider Relations-<u>Illegible forms will be returned)</u>		
Section 1 (PR Dept)	**PR Rep (Required)**	
	Contract Type	☐PCP ☐SCP ☐PCPGrp ☐SCPGrp ☐Multi Spec ☐Hosp ☐MOU ☐LOA ☐CHC ☐IPA/PHO* *Attach joinder or list of MD's according to terms of contract
	Contract Status	☐**New** ☐**Existing**
	Contract Name	
Section 2 (PO Dept)	**Contract Effec Date (Required)**	
	Contract Info Verified by	

Please send this form to:

AgeWell New York
Attn: Provider Relations
Fax: 855-585-9286
Email: ProviderRelations@agewellnewyork.com