



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 : <input type="checkbox"/> Yes <input type="checkbox"/> No	
Applying as: <input type="checkbox"/> PCP <input type="checkbox"/> SCP <input type="checkbox"/> PCP/SCP <input type="checkbox"/> Allied Health Professional <input type="checkbox"/> Hospitalist		Panel Status (PCP Only): <input type="checkbox"/> Open (Accepting new patients) <input type="checkbox"/> Existing Patients Only <input type="checkbox"/> Closed (Not accepting any patients) <input type="checkbox"/> Nursing Home Only (Limited to Nursing Homes)	
Primary Specialty:		Secondary Specialty:	
Are you board certified: <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, board name:	
Are you registered with CAQH? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> PCP <input type="checkbox"/> SCP <input type="checkbox"/> PCPGrp <input type="checkbox"/> SCPGrp <input type="checkbox"/> Multi Spec <input type="checkbox"/> Hosp <input type="checkbox"/> MOU <input type="checkbox"/> LOA <input type="checkbox"/> CHC <input type="checkbox"/> IPA/PHO* *Attach joinder or list of MD's according to terms of contract
	Contract Status	<input type="checkbox"/> New <input type="checkbox"/> 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