Provider Data Form

Group Name:	Tax ID:	Provider Gender (M or F):
Provider Last Name:	Provider First Name:	Provider Middle Initial:
Are you registered with CAQH? ____ Yes ____No	If yes, CAQH Provider ID: ____________________	
Provider's Email:	Individual NPI:	Individual FL Medicaid ID:
Primary Specialty:	Additional Specialty:	Taxonomy Code:
Board certified? Yes No	Name of Board:	Exp Date of Board:
Provider Ethnicity + Race:	FL Medical License Number:	Gender Accepted:
Group NPI:	Group FL Medicaid ID:	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 (Yes/No):
Contact Name: / Contact Phone Number:	Office Hours:	
Contact Email:		
Billing Street Address:	Suite #:	
Billing City:	Billing State:	Billing Zip Code:
Billing Phone:	Billing Fax:	Appear in Directory (Yes/No):

Office Hours:

Sun	Mon	Tues	Wed	Thurs	Fri	Sat

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

Provider Data Form

Additional Addresses

*Circle 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 (Yes/No):

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 (Yes/No):

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 (Yes/No):

Office Hours:

Sun	Mon	Tues	Wed	Thurs	Fri	Sat