



PROVIDER DATA DEMOGRAPHIC INFORMATION

GROUP PRACTICE/FACILITY INFORMATION (to be completed for Groups or Facilities only)		
Group / Facility Name: _____		
Specialty: _____		Subspecialty: _____
Billing Tax ID: _____	Group NPI: _____	Group TPI: _____
Primary Taxonomy #: _____	Additional taxonomy #s: _____	
Do you perform Advanced Imaging Services (CT/CTA, MRI/MRA, PET scan)?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Wheeled Mobility / QRP Certified?		Yes <input type="checkbox"/> No <input type="checkbox"/>

PROVIDER INFORMATION		
Professional Category: MD <input type="checkbox"/> DO <input type="checkbox"/> FNP <input type="checkbox"/> PA <input type="checkbox"/> Other <input type="checkbox"/> _____	Is provider registered with CAQH? Yes <input type="checkbox"/> No <input type="checkbox"/>	CAQH#: _____
Applying As: PCP <input type="checkbox"/> Specialist <input type="checkbox"/> PCP/Specialist <input type="checkbox"/>	Hospital Based? Yes <input type="checkbox"/> No <input type="checkbox"/>	
PCPs only: Have you received the First Dental Home Oral Evaluation and Fluoride Varnish Certification from the State? Yes <input type="checkbox"/> No <input type="checkbox"/>	Gender? Male <input type="checkbox"/> Female <input type="checkbox"/>	
Last Name: _____	First Name: _____	
Primary Specialty: _____	Subspecialty: _____	
Billing Tax ID: _____	Individual NPI: _____	License # _____
TPI: _____	EPSDT#: (THSTEPS)	Medicare #: _____
Primary Taxonomy #: _____	Additional taxonomy #s: _____	

ADDRESS INFORMATION – List primary location below & additional practice locations on page 2. <i>Note: Billing Address will be the address on the W-9.</i>		
Primary Practice Address: _____		
City: _____	State: _____	Zip: _____
Phone: _____	Fax: _____	
Hours of Operation: <input type="checkbox"/> Mon – Fri 8 – 5 or fill in below Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____		
Is mailing address same as practice address? Yes: <input type="checkbox"/> No: <input type="checkbox"/> If no, complete below		
Mailing Address: _____		
City: _____	State _____	Zip _____
Email address: _____		Contact person name: _____

SERVICES INFORMATION	
Languages Spoken: Spanish <input type="checkbox"/> Other <input type="checkbox"/> _____	Accepting New Patients? Yes <input type="checkbox"/> No <input type="checkbox"/>
Practice Limitations: None: <input type="checkbox"/> Male only: <input type="checkbox"/> Female only: <input type="checkbox"/> Age: <input type="checkbox"/> _____ Other: <input type="checkbox"/> _____	

REQUIRED FOR STAR HEALTH (Foster Care) PROVIDERS ONLY.		
Please answer whether you have experience in treating any of the following:		
Children with Post-traumatic Stress Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Children with sexual abuse	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Children with physical abuse	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Children with developmental disabilities	Yes <input type="checkbox"/>	No <input type="checkbox"/>

FOR SHP USE ONLY:	New Load <input type="checkbox"/> Update <input type="checkbox"/>	AMISYS: _____	Effective Date: _____
Products provider is contracted with: CHIP RSA (CE) <input type="checkbox"/> CHIP (KD) <input type="checkbox"/> CHIP Perinate (PM) <input type="checkbox"/> Star (MD) <input type="checkbox"/> Star+Plus (LT) <input type="checkbox"/> Star Health(FC) <input type="checkbox"/> Medicare (MC) <input type="checkbox"/>			
Payclass (1) : _____		Payclass (2): _____	Medicare Payclass _____

Additional Practice Locations

Practice Address:		
City:	State:	Zip:
<input type="checkbox"/> Mon – Fri 8 – 5 or fill in below Hours of Operation: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____		
Practice Address:		
City:	City:	
<input type="checkbox"/> Mon – Fri 8 – 5 or fill in below Hours of Operation: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____		
Practice Address:		
City:	State:	Zip:
<input type="checkbox"/> Mon – Fri 8 – 5 or fill in below Hours of Operation: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____		
Practice Address:		
City:	State:	Zip:
<input type="checkbox"/> Mon – Fri 8 – 5 or fill in below Hours of Operation: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____		
Practice Address:		
City:	State:	Zip:
<input type="checkbox"/> Mon – Fri 8 – 5 or fill in below Hours of Operation: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____		
Practice Address:		
City:	State:	Zip:
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City:	State:	Zip:
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Practice Address:		
City:	State:	Zip:
<input type="checkbox"/> Mon – Fri 8 – 5 or fill in below Hours of Operation: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____		