Iowa Total Care Practitioner Data Form

Instructions:

- Information on this Data Form must be provided in its entirety for **each participating Practitioner** (in your individual practice, group practice, or facility-based group).
- Please submit a copy of the Provider's W-9 (one per tax entity) if not previously submitted with request to contract.
- If needed, attach additional location pages. Location pages must be provided for each practitioner.
- Please be sure to include the Medicaid ID number.
- If a Practitioner participates with CAQH, please provide information on Page 2 and allow Centene Corporation access to your application information. (Must be attested within 120 days)
- If a Practitioner does not participate with CAQH, please complete the Iowa Statewide Universal Practitioner Credentialing Application instead of this form.
- Behavioral Health Providers must complete Behavioral Health Addendum (one per tax entity.)
- We have a Roster template available which is required for a group of 30 or more practitioners, please provide the practitioner details through that form instead, the CAQH and/or Iowa Statewide Universal Practitioner Credentialing Application requirements still apply on the Roster.
- Provider Accessibility Initiative (PAI) Survey. The PAI Survey must be submitted for each service location and can be found at the following link: https://www.iowatotalcare.com/providers/contracting---credentialing/improving-accessibility.html

Please return this form along with any supporting documentation (CAQH application or the Iowa Statewide Universal Credentialing Application, Behavioral Health Addendum, dated and signed W9, etc.) to Iowa Total Care via email at NetworkManagement@IowaTotalCare.com or via fax to 1-833-208-1397. You may also send a copy by USPS to Attn: Network Management c/o Iowa Total Care, 1080 Jordan Creek Parkway, Suite 100 S., West Des Moines, IA 50266. Please keep your set of originals for reference.

Date Completed:	Individual NPI:	
Are you registered with CAQH? **Yes** **No** (If No, then must complete Universal Practitioner Application <u>if not hospital-based</u>)	**If yes, CAQH Provider ID:**	
Last Name:	**First Name:**	**Middle Initial:**
Date of Birth:	**Social Security #:**	**Medicaid ID:**
Medicare #	**Are you a hospital-based practitioner, not practicing in an office setting? Yes No**	
Title/Degree (MD, DO, PhD, LCSW, LPC, NP, etc.):		
Practitioner Primary Specialty:		
Has Provider completed Cultural Competency Training? Yes No		
If Yes, did the training include the following? African American Yes No Asian Yes No Alaskan Native Yes No Hispanic/Latino Yes No American Indian Yes No Pacific Islander Yes No Other Yes No		
License Number:	**License State:**	**Exp. Date:**
Are you board certified? Yes No	**If yes, board name:**	**Exp. Date:**

Billing Information (Complete this section if different than the W9):

Pay to Name (Issue Check to): Note: May be different than the name on the 1099.		
Pay to Address (Send remittance to):	**City State, Zip:**	**Phone Number :**
Billing Contact Name:	**Billing Contact Email:**	**Fax Number:**

Location Information 1 of _______

Location Name:	Group NPI: (If none, please indicate N/A)	Tax ID:
Location Street Address:	Location City/State:	Location Zip Code:
Location County:	Primary Phone:	Primary Fax:

Email Address:	Website URL: (www.)

Credentialing Contact Information (Name, Address, E-mail, Phone Number):

Applying as: Specialist
Primary Care Provider (Provider Types that may serve as PCP: Family practitioner, General practitioner, Internal Medicine, Pediatrician, Advanced Registered Nurse Practitioner, OBGYN, and Physician Assistant)

Display in Find-A-Provider Portal? Yes No	Languages Spoken (including American Sign Language):

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
24 Hours 8 – 5 Monday - Friday							

If PCP, are you accepting new patients? Yes No	Gender or Age restrictions? Gender: None Female Only Male Only Age: None Age Limits: Lowest Age Highest Age

Hospital Services Offered (Check all that apply) Emergency Setting Post Stabilization Services

Was the Provider Accessibility Initiative (PAI) Survey submitted for this location?
Yes No

The Provider Accessibility Initiative (PAI) Survey can be found at the following link:
https://www.iowatotalcare.com/providers/contracting---credentialing/improving-accessibility.html

Does this location provide Laboratory Services? Yes No
If Yes, Accrediting/Certifying program (CLIA, COLA, MLE, etc.) ID Number:

Location Information 2 of ______

Location Name:	**Group NPI:** (If none, please indicate N/A)	**Tax ID:**
Location Street Address:	**Location City/State:**	**Location Zip Code:**
Location County:	**Primary Phone:**	**Primary Fax:**

Email Address:	**Website URL: (www.)**

Credentialing Contact Information (Name, Address, E-mail, Phone Number):

Applying as: **Specialist**
Primary Care Provider **(Provider Types that may serve as PCP: Family practitioner, General practitioner, Internal Medicine, Pediatrician, Advanced Registered Nurse Practitioner, OBGYN, and Physician Assistant)**

Display in Find-A-Provider Portal? Yes No	**Languages Spoken (including American Sign Language):**

Office Hours	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

24 Hours **8 – 5 Monday - Friday**

If PCP, are you accepting <u>new</u> patients? Yes No	**Gender or Age restrictions?** **Gender:** None Female Only Male Only **Age:** None Age Limits: Lowest Age Highest Age

Hospital Services Offered (Check all that apply) Emergency Setting Post Stabilization Services

Was the Provider Accessibility Initiative (PAI) Survey submitted for this location?
Yes No
The Provider Accessibility Initiative (PAI) Survey can be found at the following link:
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