Iowa Total Care Provider Data Form

Instructions:

- Information on this Data Form must be provided in its entirety for **each participating Provider** (individual practice, group practice, ancillary or facility).
- 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 pages.
- Please be sure to include the Medicaid ID number.
- If a Provider participates with CAQH, you may optionally provide this information and allow Centene Corporation access to your application information. (Attested within 120 days)
- Behavioral Health Providers must complete Behavioral Health Addendum.

Disability Access Definitions:

- **Parking (P)**: Parking spaces, including van-accessible space(s), are accessible. Pathways have curb ramps between the parking lot, office and at drop-off locations.
- **Exterior Building (EB):** There is an accessible ramp to the building. Curb ramps and other ramps to the building are wide enough for a wheelchair/scooter. Handrails are provided on both sides of the ramp. Doors are wide enough to allow entrance for a wheelchair/scooter and the doors have handles that are easily opened
- **Interior Building (IB):** Doors are wide enough for a wheelchair/scooter and have handles that are easily opened. There are interior ramps available and the ramps have handrails. If an elevator is present, it must be available for use by the public and members. The elevator has easy-to-hear sounds and Braille buttons within reach. The elevator is large enough for a wheelchair/scooter to turn around. If a chair lift is present, it can be utilized without help.
- **Programmatic Access (PA):** Programmatic access includes, but is not limited to: methods of communicating with member for the provision of individual medical information and general health information; appointment scheduling procedures and time slots; and system-wide coordination and flexibility to enable access.

Please return this form along with your Iowa Total Care Individual/Ancillary /Facility Application and any support documents (Iowa Disclosure of Ownership, CAQH number or 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 yes, CAQH Provider ID:**	
Last Name:	**First Name:**	**Middle Initial:**
Date of Birth:	**Social Security #:**	**Medicaid ID:**
Medicare #	**Are you a hospital-based only provider not practicing in an office setting?** ☐ **Yes** ☐ **No**	
Title/Degree (MD, DO, PhD, LCSW, LPC, NP, etc.):		
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:**	**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):

Applying as: ☐ **Specialist**
☐ **Primary Care Provider (e.g., Primary Care Physician, Mid-Level Provider, etc.)**

Primary Specialty:	**Taxonomy:**	**Display in Find-A-Provider?** ☐ **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** ☐ **Yes, existing patients only**	**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**

Disability Access? (Check all that apply). Are you in compliance with Iowa Total Care's minimum standard of disability access related to Parking, Exterior and Interior Building, and Programmatic access?
For a list of minimum standards, contact 1-855-688-6589.

Parking ☐**Yes**☐**No** **Exterior Building** ☐**Yes**☐**No**
Interior Building ☐**Yes**☐**No** **Programmatic Access** ☐**Yes**☐**No**

If you check "Yes", you certify you meet **all** of the minimum standards.

Does this location provide Laboratory Services? ☐ **Yes** ☐ **No**
If Yes, Accrediting/Certifying program (CLIA, COLA, MLE, etc.)_ID _____

Location Information 2 of ___

Location Name:	**Group NPI:**	**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):

Applying as: ☐ **Specialist**
☐ **Primary Care Provider (e.g., Primary Care Physician, Mid-Level Provider, etc.)**

Primary Specialty:	**Taxonomy:**	**Display in Find-A-Provider?** ☐ **Yes** ☐ **No**	**Languages Spoken (including American Sign Language):**

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

☐ **24 Hours** ☐ **8 – 5 Monday - Friday**

License Number:	**License State:**	**Exp. Date:**
Are you board certified? ☐ **Yes** ☐ **No**	**If yes, board name:**	**Exp. Date:**
If PCP, are you accepting new patients? ☐ **Yes** ☐ **No** ☐ **Yes, existing patients only**	**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**

Disability Access? (Check all that apply). Are you in compliance with Iowa Total Care's minimum standard of disability access related to Parking, Exterior and Interior Building, and Programmatic access?
For a list of minimum standards, contact 1-855-688-6589.

Parking ☐**Yes**☐**No** **Exterior Building** ☐**Yes**☐**No**
Interior Building ☐**Yes**☐**No** **Programmatic Access** ☐**Yes**☐**No**

If you check "Yes", you certify you meet **all** of the minimum standards.

Does this location provide Laboratory Services? ☐ **Yes** ☐ **No**
If Yes, Accrediting/Certifying program (CLIA, COLA, MLE, etc.)_ID _____