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 Council for Affordable Quality Health Care (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. The Provider Accessibility Initiative (PAI) Survey must be submitted for each service location and can be found at the following link: 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 W-9, etc.) to Iowa Total Care:

- By email: NetworkManagement@IowaTotalCare.com
- By fax: 1-833-208-1397
- By mail: Iowa Total Care
  Attn: Network Management
  1080 Jordan Creek Parkway, Suite 400 South
  West Des Moines, IA 50266

Please keep your set of originals for reference.

Date Form Completed:	Individual Practitioner NPI:

Requested Effective Date of Enrollment: *(This date cannot be prior to their enrollment with Iowa Medicaid or prior to their contract effective date.)*

Are you registered with CAQH? ☐ Yes ☐ No *(If No **AND not hospital-based**, then must complete Universal Practitioner Application)*	If yes, CAQH Provider ID:

Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security Number:	Medicaid ID:
Medicare Number:	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	Other _____	☐ Yes ☐ No
Alaskan Native	☐ Yes ☐ No	Hispanic/Latino	☐ Yes ☐ No		
American Indian	☐ Yes ☐ No	Pacific Islander	☐ Yes ☐ No		

Practitioner Race *(Optional)*:	Practitioner Ethnicity *(Optional)*:
☐ American Indian and Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	☐ Hispanic or Latino ☐ Non-Hispanic or Latino

License Number:	License State:	Exp. Date:
Are you board certified? ☐ Yes ☐ No	If yes, board name:	Exp. Date:

Billing Information *(Note: Pay To/Billing Address must match W-9 form.)*

Pay To Name *(Issue check to)*:		
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:**	

Credentialing Contact Information *(Name, Address, Email, Phone Number)***:**

Applying as: ☐ **Specialist**
☐ **Primary Care Provider**
(Provider types that may serve as primary care provider (PCP): family practitioner, general practitioner, internal medicine, pediatrician, advanced registered nurse practitioner, OBGYN, and physician assistant)

Display on Find A Provider site?
☐ **Yes** ☐ **No**

Languages Spoken *(including American Sign Language)***:**

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

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

Accepting new patients at this location?
☐ **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 via the following link:
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:**	

Credentialing Contact Information *(Name, Address, Email, Phone Number)***:**

Applying as: ☐ **Specialist**
☐ **Primary Care Provider**
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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**

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