PROVIDER CREDENTIALING FORM

Submission Date: _____
Effective Date: _____

Thank you for your interest in becoming a ConnectiCare participating provider. ConnectiCare and the Council for Affordable Quality Healthcare (CAQH) have joined forces to provide an online credentialing application database. To update your application or learn more about CAQH, visit www.caqh.org.

Note: If you are a behavioral health or chiropractor provider, please do not use this form. Call the following numbers for credentialing information:

- Behavioral health credentialing call Optum Health Behavioral Services at 1-800-333-8724
- Chiropractor credentialing call Optum Physical Health at 1-800-873-4575

This form and a W9 must be completed to begin the credentialing process. Please fax the completed form to 866.561.9260 or CCICredentialing@Connecticare.com.

- To be listed in the directory for a specific location, the provider must actively be seeing patients at the location on a regular and consistent basis but, in no event, less than once per week. A "regular and consistent basis" does not include covering physicians who are in the office occasionally.
- This form needs to be completed in its entirety to be added to the provider directory.

Last Name	M.I.	First Name
CAQH #: Add ConnectiCare to your list of "Authorized Health Plans" or choose the "Global Access" option and update your application to reflect current information.		
Title: ☐ MD ☐ DO ☐ DC ☐ PA* ☐ APRN/NP* ☐ Other-please provide your title: _____ **Midlevel providers only*: Provide the name of your supervisor/collaborating physician: _____		
☐ PCP** ☐ Specialist ☐ Allied Health Professional **APRN/NPs must attach your Nursing Certification **Massachusetts PA PCPs must attach your PA Certification and Collaborative Agreement	**PCPs only**: Number of working hours per week: _____ Are you accepting new patients? ☐ Yes ☐ No	
Specialty:	Board Certified? ☐ Yes ☐ No ☐ N/A If Yes, please list Board Name:	
Date of Birth:	SSN #:	☐ Male ☐ Female
Licensed State:	License #:	Individual's NPI #:
Federal DEA #:	Tax ID #:	Terminating Tax ID# (if applicable):
Do you practice exclusively in an inpatient setting, i.e., patients cannot call and make an appointment to see you? ☐ Yes ☐ No If Yes, please list hospital:		
Does your office provide online services, i.e., prescription refills, appointments, clinical questions, etc.? ☐ Yes ☐ No		

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ConnectiCare

Section 1: Primary Location			
Group Name (if applicable):			
Primary Practice Location Street Address:			
Primary Practice Location City:		State:	Zip:
Primary Practice Phone #:	Primary Practice Fax #:		
Group TIN #:	Group NPI #:		
Do you see patients on a regular and consistent basis, **at least one day a week**, in the above location? ☒ Yes ☐ No Should this location be included in the provider directory? ☐ Yes ☐ No			
Payment address same as: ☐ Practice ☐ Mailing ☐ Other Street Address:			
City:		State:	Zip:
Mailing address same as: ☐ Practice ☐ Payment ☐ Other Street Address:			
City:		State:	Zip:
Mailing Office Phone #:	Mailing Office Fax #:		

Section 2: Secondary Location			
Group Name (if applicable):			
Practice Location Street Address:			
Practice Location City:		State:	Zip:
Practice Phone #:	Practice Fax #:		
Group TIN #:	Group NPI #:		
Do you see patients on a regular and consistent basis, **at least one day a week**, in the above location? ☒ Yes ☐ No Should this location be included in the provider directory? ☒ Yes ☐ No			

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For additional Practice Locations, please attach other pages to this form with the same information requested in Section 2.

Section 3: General Office Contact Information	
Group/Practice's Contact Name:	
Email Address:	Direct Phone #:

Section 4: Credentialing Contact Information	
Group/Practice's Credentialing Contact Name:	
Email Address:	Direct Phone #:

PLEASE ATTACH THESE ITEMS TO THE APPLICATION:

- ☐ W-9 (all W-9's referenced in Recruited Service Addresses section, must be signed and dated)
- ☐ Roster or listing on letterhead confirming group provider status (Group Agreement Only)
- ☐ Collaborative agreement (if applicable)
  - Nurse Practitioner Services
  - Physician Assistant
  - Midwifery Services
- ☐ Participating hospital privileges or coverage arrangements with participating provider

Applicants have the right to review the information submitted in support of their application and to correct erroneous information. ConnectiCare, Inc. & Affiliates will notify the applicant of any information obtained during the credentialing process that varies substantially from the information submitted.