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 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 100S
  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 the IME or prior to their contract effective date)*		
Are you registered with CAQH? ☐ **Yes** ☐ **No** *(If No, then must complete Universal Practitioner Application if not hospital-based)*	**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**		
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 W-9.)*

Pay To Name (Issue check to): *(Note: May be different than 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:**	

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:**	

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)

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