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.
- 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:
  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 the Iowa Medicaid 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		

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, E-mail, 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 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**

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 at 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, E-mail, Phone Number):

Applying as: ☐ **Specialist**
☐ **Primary Care Provider**
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Hospital Services Offered *(Check all that apply.)* ☐ **Emergency Setting** ☐ **Post Stabilization Services**

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