Dear Provider,

* Please Create your own Provider ID and password = **CAQH Web Site (ProView)** = <https://proview.caqh.org/>
* Complete your CAQH Profile OR fill in the form below, **SCAN and e-mail this as well as copies of the required, current documents CONFIDENTIALLY** to dataipomail@gmail.com to complete your profile

|  |
| --- |
| All the information below is current, accurate and approved by the Provider: |
| **1A. Date:**  | **1B. Provider Signature**: |
| **1C. PROVIDER NAME (as it appears on the State License you are practicing in) =** |
| **1D. Previous /other PROVIDER Names =**  |
| **1E. Date of Birth** |  |
| **1F. Gender** | **[ ] Male [ ] Female** |
| **1G. Daytime Phone Number (w/area code) =** |
| **1H. Mailing/ Billing Address for business =** |
| **1I. e-Mail Address =** |
| **1J. Current, Credential Status**  |  |
| **#** | **Req.** | **ITEM** | **YOUR INFORMATION** | **DATES, STATUS** |
| 2A | **\*** | **CAQH-supplied Provider ID Number** |   |  |
| 2B | **\*** | **Corresponding CAQH ID-Password** |   |  |
| 3 | \* | Previously completed credentialing application, where? |   |  |
| 4 | **\*** | **Business Name** |   |  |
| 5 | **\*** | **Practice Specialty** |   |  |
| 6 |   | Recent Photograph |   |  |
| 7 | \* | Social Security Number  |   |  |
| 8 |   | Ethnicity |   |  |
| 9 |   | Citizenship Information |   |  |
| 10 |  | **IDENTIFICATION NUMBERS:** |   |  |
| 11 | \* | **Individual Tax ID (UPIN)** |   |  |
| 12 | \* | **Provider NPI Number** |   |  |
| 13 | \* | **Medicare - NPI** |   |  |
| 14 | \* | **Medicare – PTAN, UPIN** |   |  |
| 15 | \* | **Medicaid** |   |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 16 |  | **PRACTICE LOCATIONS, Current:** | **YOUR INFORMATION** | **DATES, STATUS** |
| 17 | \* | **Practice Address 1** |   |  |
| 18 | \* | Practice Tax ID Number |   |  |
| 19 | \* | Practice Phone Number |   |  |
| 20 | \* | Primary Practice Contact |   |  |
| 21 |  | **Practice Address 2** |   |  |
| 22 |  | Practice Tax ID Number |   |  |
| 23 |  | Practice Phone Number |   |  |
| 24 |  | Primary Practice Contact |   |  |
| 25 |  | **PRACTICE LOCATIONS, Previous:** |   |  |
| 26 | \* | **Previous, Practice Address 1** |   |  |
| 27 | \* | Practice Tax ID Number |   |  |
| 28 | \* | Practice Phone Number |   |  |
| 29 | \* | Primary Practice Contact |   |  |
| 30 |  | **Previous, Practice Address 2** |   |  |
| 31 |  | Practice Tax ID Number |   |  |
| 32 |  | Practice Phone Number |   |  |
| 33 |  | Primary Practice Contact |   |  |

We will Confidentially correspond back and forth as needed with this and all other required information and supporting documentation.

Thank You for the preliminary information.

Sincerely,

DATAIPO LLC