Provider Data Form (*For credentialing purposes)*

To begin your credentialing process, please complete this form in its entirety and submit to **providerrelationsny@seniorwholehealth.com**, or fax a printed copy to: 1-855-818-4873. If you are registered with CAQH Universal Credentialing DataSource, **please contact CAQH to authorize Senior Whole Health access to provider's credentialing file.**

<table>
<tr><td>Date:</td><td colspan="2">Date of Birth:</td><td colspan="4">NPI #:</td></tr>
<tr><td colspan="3">First Name:</td><td colspan="2">Last Name:</td><td>Middle Initial:</td><td>Title:</td></tr>
<tr><td colspan="4">Primary Practice Name:</td><td colspan="3">Contact Name:</td></tr>
<tr><td colspan="3">Primary Practice Address:</td><td>Ste:</td><td colspan="2">City, State, Zip:</td><td>County:</td></tr>
<tr><td colspan="2">Primary Phone:</td><td colspan="2">Primary Fax:</td><td colspan="3">Secure Email:</td></tr>
<tr><td colspan="4">Billing Company Name (to whom payments are sent):</td><td colspan="3">Billing Tax ID:</td></tr>
<tr><td colspan="3">Billing Address (where payments go):</td><td>Ste:</td><td colspan="3">City, State, Zip:</td></tr>
<tr><td colspan="2">Billing Phone:</td><td colspan="2">Billing Fax:</td><td colspan="3">Contact Name:</td></tr>
<tr><td>Provider Type: -</td><td colspan="3">Applying as: -</td><td colspan="3">Panel Status (PCP only): -</td></tr>
<tr><td colspan="4">Primary Specialty:</td><td colspan="3">Secondary Specialty:</td></tr>
<tr><td colspan="4">Are you board certified: ☐Yes ☐No</td><td colspan="3">If yes, board name:</td></tr>
<tr><td colspan="4">Are you registered with CAQH? ☐ Yes ☐ No</td><td colspan="3">If yes, CAQH Provider ID:</td></tr>
</table>

<u>Primary Office Hours:</u>

Mon: Tues: Wed: Thurs: Fri: Sat: Sun:

Language(s) spoken: Handicapped Accessible: ☐Yes ☐ No

If you are not registered with CAQH, please provide the following additional information, which is necessary to register you with the CAQH Universal Credentialing DataSource.

Primary Fax No.:	E-Mail Address:
Social Security Number:	DEA Certificate No.:
State License No.:	Licensed State:
UPIN:	Tax ID:

Credentialing and Contract Address: (please complete even if same as primary address)

Credentialing Address Name:		Credentialing Contact Name:	Phone:	Fax:
Credentialing Street Address:	Ste:	City, State, Zip:		
Contract Legal Name: (for new contracts only)		Contract Contact Name:	Phone:	Fax:
Contract Street Address:	Ste:	City, State, Zip:		
Contract Signer Name:				

Additional Practice / Billing Addresses: (if you need additional space, please attach SWH spreadsheet)

Additional Practice Name:		Practice Phone:	Practice Fax:	Practice Contact Name:
Additional Practice Address:	Ste:	City, State, Zip:		
Billing Company Name (if different than primary billing):			Billing Tax ID:	
Billing Address:	Ste:	City, State, Zip:		
Billing Phone:	Billing Fax:		Billing Contact Name:	

Additional Practice Name:		Practice Phone:	Practice Fax:	Contact Name:
Additional Practice Address:	Ste:	City, State, Zip:		
Billing Company Name (if different than primary billing):			Billing Tax ID:	
Billing Address:	Ste:	City, State, Zip:		
Billing Phone:	Billing Fax:		Billing Contact Name:	

NOTES:

FOR INTERNAL PURPOSES ONLY		
Section 1 (PR Dept)	PR Rep Name: (Required)	Provider currently is: ☐ Par ☐ Non-Par
	Contract Type: - *Attach joinder or list of MD's according to terms of contract	Contract Status: ☐ New ☐ Existing Provider to appear in Provider Directory: ☐Yes ☐ No
	Contract Name/Legal Name:	
Section 2 (PO Dept)	Contract Effect Date: (Required)	
	Contract Info Verified by :	
	Billing Group ID #	