INVENIRE MEDICOS

# Provider Data Form

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| Date: | | | Are you registered with CAQH? ☐ Yes ☐ No |
| If Yes, CAQH Provider ID: | | | Individual NPI: |
| Last Name: | First Name: | | Middle Initial: |
| Date of Birth: | Social Security #: | | Medicaid ID #: |
| Provider Type (MD, DO, PhD, LCSW, LPC, etc.): | | Are you a hospital based only provider not practicing in an office setting? ☐ Yes ☐ No | |
| Tax ID: | | Group Billing NPI: | |
| Practice Name: | | E-Mail Address: * | |
| Primary Office Street Address: | | | Suite #: |
| Primary Office City: | State: | County: | Zip: |
| Primary Telephone: | | Primary Fax: | |
| Credentialing Contact Information (Name, Address, E-Mail): | | Primary Specialty: | |
| Office Hours :<br>Monday ☐_____to_____Friday ☐_____to<br>Tuesday ☐_____to_____ Saturday ☐_____to<br>Wednesday ☐to Sunday ☐_to_____<br>Thursday ☐to_____ | | Applying As: ☐Specialist<br>☐Primary Care Provider (e.g., Primary Care Physician, Mid- level provider) | |
| If PCP, are you accepting new patients?<br>☐ Yes ☐ No<br>☐ Yes, existing patients only | | What gender or age restrictions do you have?<br>Gender: ☐ No Restrictions ☐ Female Only ☐Male Only<br>Age: ☐ No Restrictions ☐ Age Limits: Lowest Age_____Highest Age _____ | |
| License Number: | License State: | | Exp. Date: |
| Are you board certified?<br>☐ Yes ☐ No | If Yes, board name: | | Exp. Date: |
| Please list any medical related organizations you have ownership with, e.g., laboratory, home health agency, radiology facility, mobile testing, MRI, etc. | | | |
| If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one. | | | |
| Do you have a CLIA Certificate? ☐Yes ☐ No | Do you have a CLIA waiver? ☐ Yes ☐ No | Type of Service Provided: | |
| Certificate Number:<br>Certificate Expiration Date: | | CLIA Name:<br>Tax ID #: | |
| Secondary Office Street Address: (include any additional locations on a separate page) | | | Suite #: |
| Secondary Office City: | | State: County: Zip: | |
| Secondary Telephone: | | Secondary Fax: | |

Note: Fill out the form and send via email at inveniremed@gmail.com .