CarePartners of Connecticut

ANCILLARY PRACTITIONER DATA FORM: CHIROPRACTOR

Please email to AncillaryNetworkContracting@point32health.org or fax to **617.673.0909.**

Please note: A credentialing application must also be submitted at proview.caqh.org.

GENERAL INFORMATION – MISSING INFORMATION WILL DELAY YOUR APPLICATION

Name _____
Last First Middle Degree/Specialty

Individual NPI _____ Date of birth____/____/_____ SS# _____-_____-_____

Provider's email _____

DBA, Group or Practice Name (if applicable) _____

Are we adding you to a group practice? YES ☐ NO ☐ Are you a Medicare participating provider (required)? YES ☐ NO ☐

CAQH Information

Is your CAQH application updated and re-attested to within the last 3 months? YES ☐ NO ☐
Did you include 5-year work history in CAQH in month/year format? YES ☐ NO ☐
Have you granted Tufts Health Plan access to your CAQH account? YES ☐ NO ☐

CAQH ID# _____
*If you do not have a CAQH ID#, please call us at **888.880.8699**.*

Payment Information Payee NPI _____ Tax ID# ____-_____

To whom should checks be made payable? _____

Payment Address (should match W-9 & CAQH) Payment Address Phone _____ Fax _____

Street _____ City, State ZIP _____

Mailing Address Mailing Address Phone _____ Fax _____

Street _____ City, State ZIP _____

Practice Address (general liability insurance must be attached for all practice locations)

Street _____ Phone _____

City, State ZIP _____ Fax _____

Service Hours: Mon_____Tue_____Wed_____Thu_____Fri_____Sat_____Sun_____

_____ Handicap access? Yes ☐ No ☐ Are translation services available? Yes ☐ No ☐
Languages other than English at this location

For additional addresses check here ☐ and attach a separate sheet. Please include all practice addresses for directories and update all addresses with caqh.org/.

Please provide the contact information for the person we should contact if we have any questions about your application:

Name _____ Phone _____ Fax _____

Email _____

REQUIRED CREDENTIALING/CONTRACTING DOCUMENTS – Please attach

☐ Documentation of current professional liability insurance ($1 million per incident/$3 million aggregate). Must show the individual provider's name on the certificate, roster or a letter from the insurance company unless the professional liability information in CAQH is current and attested to. ***(required)***

☐ Completed Past 5 Years' Work History Form ***(required)***

☐ Form W-9 for payments (payment address should match CAQH and above) ***(required)***

☐ Documentation of your (or your landlord's) current general liability "premises" insurance ($1 million per incident/$1 million aggregate). Must show addresses for any/all practice sites. This coverage should include, but not be limited to, claims for bodily injury, property damage and legal liability on the insured's premises. ***(required)***

Internal Use:

PROV ID _____ GROUP/PAYEE _____ SPEC 6600

PCAT 01 05, TOP 37, PRAC 01 02 REST EX 77

05 (#5166774) PI Initials _____ Date_____ PO Initials _____ Date _____