CarePartners of Connecticut

ANCILLARY PRACTITIONER DATA FORM: PT/OT/ST/AUDIOLOGY 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 for PTs)? YES ☐ NO ☐

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

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 proview.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 _____

TYPE OF PRACTITIONER – Check all that apply

☐ Physical Therapist
☐ Occupational Therapist - ☐ Check here if Certified Hand Therapist
☐ Speech Therapist - ☐ Check here if ASHA certified
☐ Audiologist - ☐ Check here if ASHA certified ☐ CCC-A

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 (enclosed) ***(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)***

☐ Signed and dated Credentialed vs. Contracted form (enclosed) ***(required for all except audiologists)***

Internal Use:

PROV ID _____ GROUP/PAYEE _____ SPEC 9900

PCAT 01 05, TOP 34 35 53, PRAC 01 02 05 REST EX 77

(#5166778) PI Initials _____ Date_____ PO Initials _____ Date _____

Credentialed vs. Contracted

I understand that although I will have to be fully credentialed by CarePartners of Connecticut, I am not a contracted provider. I acknowledge that it has been disclosed to me that the only contractual arrangement I have with CarePartners of Connecticut is through the _____ group.

_____
Clinician signature

_____
Name (please print)

_____
Signatory for group (Director or Principal)

_____
Title