CareSource

PROVIDER PROFILE

THIS INFORMATION IS NEEDED BY CARESOURCE TO PROCESS CLAIMS, PRIOR AUTHORIZATIONS, AND TO MEET OUR REQUIREMENTS FOR THE STATE.

Is this a change of information about you or your billing information? ☐Yes ☐No If yes, please indicate change:

_____

Provider Name and Credentials: _____ Medicaid Provider Type: _____ ☐ Male ☐ Female

Social Security #: _____ Medical License #: _____ DEA #: _____ NPI: _____

Primary Specialty: _____ Secondary Specialty: _____

Board Certified? ☐Yes ☐ No Board Eligible? ☐Yes ☐ No Board Certified? ☐Yes ☐ No Board Eligible? ☐ Yes ☐No

Please provide all addresses where you will provide services to CareSource members. For each service address, please provide the corresponding Tax ID Name, Number and Billing Address. For additional addresses, please attach a second page.

1) **Primary** Practice Name: _____ Medicaid ID #: _____

Address: _____ City: _____ ZIP: _____

Phone #: _____ Fax #: _____ Federal Tax ID #: _____

Days and Hours provider is available to see members: _____

Name of entity reimbursement is to be made payable to: _____ Entity's NPI: _____

Billing Address: _____

Billing Phone #: _____ Billing Fax #: _____ Contact Person: _____

All other correspondence should be mailed to: ☐ Practice ☐ Billing ☐Other: _____

2) **Additional** Practice Name: _____ Medicaid ID #: _____

Address: _____ City: _____ ZIP: _____

Phone #: _____ Fax #: _____ Federal Tax ID #: _____

Days and Hours provider is available to see members: _____

Name of entity reimbursement is to be made payable to: _____ Entity's NPI: _____

Billing Address: _____

Billing Phone #: _____ Billing Fax #: _____ Contact Person: _____

All other correspondence should be mailed to: ☐ Practice ☐ Billing ☐Other: _____

NOTE: PLEASE ATTACH A W-9 (IF DIFFERENT) FOR EACH SERVICE LOCATION.

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CSMIProviderFax@caresource.com

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