Provider Data Form

For Credentialing Purposes

If you wish Peach State Health Plan to retrieve your credentialing application from the CAQH Universal Credentialing Database, please use this simple, standardized form. Please note that the top portion of this form is required information.

DATE:			
Last Name:	First Name:		Middle Initial:
Date of Birth:	Primary Telephone No.:		
Primary Office Street Address:			Suite #:
Primary Office City:	State:	County:	Zip:
Provider Type (MD, DO, DC, DDS, DMD, DPM, etc) :			
Specialty:	Applying As: ❑ PCP ❑ Specialist ❑ Allied Health Professional		
Are you board certified? Yes No	If Yes, board name:		
Are you registered with CAQH? Yes No	If Yes, CAQH Provider ID:		

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.:	Email Address:
Social Security No.:	*DEA Certificate No.:
*State License No.:	*Licensed State:
UPIN: NPI:	Tax ID: Medicaid ID:

* Required field

Note: If you have already completed your application with CAQH, please ensure that you have authorized Peach State Health Plan to access your data. Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with Peach State Health Plan Name. If you have any questions, please contact Provider Services at 1-866-874-0633 or fax to Contracting at 866-532-8869.