

Entity name (as written on W9):		Provider type: <input type="checkbox"/> Primary care provider (PCP) <input type="checkbox"/> Specialist <input type="checkbox"/> Behavioral health
Independent practice association (IPA) name (if applicable):		
Name doing business as (if applicable):		Provider TIN/EIN number (nine characters):
Primary contact name:	Primary contact email:	Primary contact phone:

Location	Group name (as it should appear in a provider directory)	Street address	Building or suite number	City	State	ZIP code + four digits	Taxonomy code	Group NPI	Phone with area code
Main practice location 1									
Pay to address									
Practice location 2									
Practice location 3									
Practice location 4									
Practice location 5									

**Please feel free to attach an additional document if more space is required.**

Practitioner roster

Practice location (from numbers listed above)	Waiver number (if applicable from the number listed below)*	First name	Last name	MI	Degree	Specialty	CAQH registration number	Taxonomy code	Medicaid ID and NPI	PCP
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No

\* Waiver: 1) Assisted living (2) AIDS/HIV home and community-based services (AIDS/HIV) (3) Elderly and disabled home and community-based services (4) Developmental disabilities home and community-based services

Entity name (as written on W9):		Provider type: <input type="checkbox"/> Primary care provider (PCP) <input type="checkbox"/> Specialist <input type="checkbox"/> Behavioral health
Independent practice association (IPA) name (if applicable):		
Name doing business as (if applicable):		Provider TIN/EIN number (nine characters):
Primary contact name:	Primary contact email:	Primary contact phone:

Location	Group name (as it should appear in a provider directory)	Street address	Building or suite number	City	State	ZIP code + four digits	Taxonomy code	Group NPI	Phone with area code
Main practice location 1									
Pay to address									
Practice location 2									
Practice location 3									
Practice location 4									
Practice location 5									

**Please feel free to attach an additional document if more space is required.**

Practitioner roster

Practice location (from numbers listed above)	Waiver number (if applicable from the number listed below)*	First name	Last name	MI	Degree	Specialty	CAQH registration number	Taxonomy code	Medicaid ID and NPI	PCP
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> N/A		Medicaid NPI	<input type="checkbox"/> Yes <input type="checkbox"/> No

\* Waiver: 1) Assisted living (2) AIDS/HIV home and community-based services (AIDS/HIV) (3) Elderly and disabled home and community-based services (4) Developmental disabilities home and community-based services