SouthCarolinaPDM@centene.com

Provider Data Form_ADD

(*Or* you may attach a full roster in MS Excel; please send DOO, W9, CLIA, etc.
This information will assist us in loading your providers without delay!)

Date:		Are you registered with CAQH? ❑ Yes ❑ No If No, please attach the SC Application.	
If Yes, CAQH Provider ID:		Individual NPI:	
Last Name:	First Name:		Middle Initial:
Date of Birth:	Social Security #:	Medicaid ID # (Note: You must have an active SC Medicaid ID or proof of application):	
Provider Type (MD, DO, NP, PA etc.):	Are you a hospital-based only provider not practicing in an office setting? ❑ Yes ❑No If *Yes and No* – Please checkmark which location is *outside* the hospital: Loc1: __☐__ Loc2: __☐__		
Tax ID (Attach W9):	Group Billing NPI (Attach Disclosure of Ownership):		
Practice Name:	Email Address for Absolute Total Care to Contact Practice:		
Primary Office Street Address:		Suite #:	
Primary Office City:	State:	County:	Zip:
Primary Telephone:	Primary Fax:		

Credentialing Contact Information Responsible for Roster Updates/Adds/Terms: Name, Title, Phone, Email Address , Mailing Address

Name: _____ Title: _____

Direct Phone #: _____ Email: _____

Mailing Address: _____ City: _____ ST: _____ ZIP: _____

Practice Hours (Monday through Sunday): M: _____ to _____ T: _____ to _____ W: _____ to _____ Th: _____ to _____ F: _____ to _____ S: _____ to _____ Sun: _____ to _____ After Hours Clinic? (Y/N) _____ After Hours Hours (Monday through Sunday):	Practice Hours (Monday through Sunday): M: _____ to _____ T: _____ to _____ W: _____ to _____ Th: _____ to _____ F: _____ to _____ S: _____ to _____ Sun: _____ to _____ After Hours Clinic? (Y/N) _____ After Hours Hours (Monday through Sunday):
Primary Specialty: High Risk OB/GYN? (Y/N): ____ Maternal/Fetal? (Y/N): ____	Applying As: ❑ Specialist ❑ Primary Care Provider (Nurse practitioners must adhere to South Carolina Department of Health and Human Services guidelines for practicing as a PCP before we can load as a PCP)

If PCP, are you accepting new patients? ❑ Yes ❑ No ❑ Yes, existing patients only	What gender or age restrictions do you have? Gender: ❑ No Restrictions ❑ Female Only ❑ Male Only Age: ❑ No Restrictions ❑ Age Limits: Lowest Age: ____ Highest Age: ____

License #:	License State:	Expiration Date:

Are you board certified? ❑ Yes ❑ No	If Yes, board name:	Expiration Date:
W-9 Attached? (Check Mark) __☐____	*Current* Disclosure of Ownership Attached? (Check Mark) __☐____	Nurse Protocol & Preceptor Documents (if NP) Attached? (Check Mark or N/A) ❑ _____
Please list any medical related organizations you have ownership with (e.g., laboratory, home health agency, radiology facility, mobile testing, MRI, etc.) DOO has all Info (Check Mark) __☐____		
If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one**.**		
Do you have a CLIA Certificate Attached? ❑ Yes ❑ No	Do you have a CLIA waiver Attached? ❑ Yes ❑ No	Type of Service Provided:
Certificate #: Certificate Expiration Date:	CLIA Name: Tax ID (TIN) #:	
Secondary Office Street Address **(include any additional locations on a separate page to order to load directory information or Mark N/A)**:	Suite #:	
Secondary Office City:	State:	County: Zip:
Secondary Telephone:	Secondary Fax:	
Practice Hours (Monday through Sunday): M:_____ to _____ T:_____ to _____ W:_____ to _____ Th:_____ to _____ F:_____ to _____ S:_____ to _____ Sun: _____ to _____ After Hours Clinic? (Y/N) _____ After Hours Hours (Monday through Sunday):	Practice Hours (Monday through Sunday): M: _____ to _____ T: _____ to _____ W: _____ to _____ Th: _____ to _____ F: _____ to _____ S: _____ to _____ Sun: _____ to _____ After Hours Clinic? (Y/N) _____ After Hours Hours (Monday through Sunday):	
Additional Locations? (Please attach roster or additional information as above for any other locations)	Any additional information for Absolute Total Care?	

Your responses will allow us to load your data appropriately and assist in preventing delays in processing your request.

Thank you for participating in Absolute Total Care!

Respectfully,

The South Carolina PDM Team