SouthCarolinaPDM@centene.com

Provider Data Form_UPDATE

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

Date:	Are you registered with CAQH? ❑ Yes ❑ No		
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 Current 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):		
W-9 Attached? (Check Mark) ☐	Disclosure of Ownership Attached? (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)	
Additional Information for Absolute Total Care?	

Your responses will allow us to review your current data and assist us in updating our systems.

Thank you for participating in Absolute Total Care!

Respectfully,

The South Carolina PDM Team