Community Health Direct

INDIANA PROHEALTH NETWORK, LLC

NEW PROVIDER DATA FORM

For Credentialing Purposes

If you wish to participate with Community Health Direct (CHD), please complete this form and return it to the email address below. Community Health Direct uses CAQH as the application for the credentialing process. The requested information is required in order for CHD to access each provider's record in the CAQH data base.

Please note-full payer credentialing from start to finish can take anywhere from 90-120 business days from the time that all requested information is received back to CHD until the time the provider is effective and fully approved to begin billing.

If you have previously completed your application with CAQH, please ensure that you have authorized us to access your data, that the application and documents are current, and that you have reattested if needed.

Date Submitted:	Date of Birth:	Degree:	
Last Name:	First Name:	MI:	
Primary Practice Phone #:	Primary Practice Fax #:	Additional Locations? #: ☐ Yes ☐ No	
Practice Legal Business Name:			
Marketing Name or d/b/a used? ☐ Yes ☐ No	If Yes, please list:		
Primary Office Street Address:			
City:	State:	County:	Zip:
Provider Type:	Specialty:		
Applying As: ☐ PCP ☐ Specialist ☐ APP		Individual NPI #:	
Are you Board Certified? ☐ Yes ☐ No	Board Name:		

Community Health Direct

Are you registered with CAQH? ☐ Yes ☐ No		If Yes, CAQH Provider ID #:
Group Tax ID #:		Group NPI #:
Individual Medicaid LPI #:		Group Medicaid LPI #:
Last 4 digits of SSN #:		Panel Status: ☐ Open ☐ Closed
State License #:		Licensed State:
DEA #:		DEA State:
Cred Contact Name:	Phone:	Email:
Cred Contact Mailing Address:		
Office Manager Name:	Phone:	Email:

Please return this form via email to:

CHDProviderRelations@ecommunity.com