Capital BLUE

For NEW GROUP Use Only

Provider Data Form

For Credentialing Purposes

To begin your credentialing process, please use this simple, standardized form. Please **email** the completed form to Capital BlueCross at CBC.CAICrecruiters@capbluecross.com.

Note: Anything marked with an asterisk (*) is a required field.

Section 1—Provider Group Information

*Date:							
Note: If you are a third party billing company, submitting changes on behalf of a provider group, you will need to have the group complete an Attestation Form.							
*Legal Entity Name:							
Group Name (DBA, *if different from Legal Entity Name*):							
*Group NPI Number:							
*Group Tax ID Number:							
*Primary Office Street Address:				Suite Number:		Medicare Number:	
*Primary Office City:		*State:		*County:		*ZIP:	
*Appointment Phone Number:				Primary Fax Number:			
Group Email Address:				*Print in Directory? ☐ Yes ☐ No			
*Primary Office Hours:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Additional Office Location Street Address (affiliated with NPI/Tax ID listed above):				Suite Number:			
Additional Office City:		State:		County:		ZIP:	
Additional Office Appointment Phone Number:				Additional Office Fax Number:			
Additional Office Email Address:				Print in Directory? ☐ Yes ☐ No			
*Correspondence Address:							
*Correspondence Phone:				Correspondence Fax:			

*Remit Address:	
*Remit Phone: (If applicable)	Remit Fax: (If applicable)
*Medical Records Address:	
*Medical Records Phone:	Medical Records Fax:
*Medical Records Contact Person:	*Medical Records Email:
Please list those who are authorized to sign contracts on behalf of the practice:	
*Name:	*Title:
*Phone:	Fax:
*Email:	**Note:** This email address is used to communicate important information. It is your responsibility to notify Capital BlueCross of any changes.
Name:	Title:
Phone:	Fax:
*Group Contact Name:	*Group Contact Phone:
*Name and Title of Individual Completing this Form:	
*Email Address: ☐ Do not have an email address	*Taxonomy Code:

Please complete Page 3—Section 2 of this form for each individual practitioner that is part of the group in Section 1.

Note: If you have already completed your application with CAQH, please ensure that you have authorized all applicable organizations to access your data. Using the CAQH Universal Provider DataSource does not grant participation or constitute applying for participation with any of the above organizations. If you are already listed with CAQH this form will allow us to pull the necessary information to begin contracting and credentialing.

Section 2—Individual Practitioner Information

*Last Name:	*First Name:	Middle Initial:
*Date of Birth:		
*Provider Type (e.g., MD, DO, DC, DDS, DMD, DPM):		
*Specialty:	*Applying As: ☐ Primary Care Physician ☐ Specialist ☐ Allied Health Professional	
*Languages:		
*Date Joined/Opened Group:	**Note:** Does not mean that this will be the effective date.	
*CAQH ID Number:	**Note:** Capital BlueCross requires practitioners to be registered with CAQH. So, if you are not already registered, please do so prior to submitting the Provider Data Form.	
*Social Security Number:		
*State License Number:	*Licensed State:	
*Individual NPI Number:	*Taxonomy Code:	
*Will provider be practicing at all locations? ☐ Yes ☐ No (If provider will be at some, but not all locations, please list the locations below)		

Service Locations	Primary:	
	Other:	
	Other:	
	Other:	
	Other:	
	Other:	

Note: If adding multiple practitioners to a group, you will need to complete Section 2 for each Practitioner being added.
Disclaimer: It is important that you notify us promptly when your status changes.