PROVIDER DATA SHEET

CAQH Provider ID

☐ **W-9 Attached**

Provider Demographics			
Last Name	First Name	MI	Degree/Title
Gender ☐ M ☐ F	SSN	DOB	
Language(s)	NPI #	License #	
Licensed State	Hospital Affiliation	Tax ID #	
Primary Specialty	Secondary Specialty	PCP ☐ Y ☐ N	Accepting New Patients ☐ Y ☐ N
Medical School Name	Year Grad	DEA #	

Address Information			
Primary Practice Name		Billing Name	
Primary Practice Address		Billing Address	
City	State Zip	City	State Zip
County	Phone #	County	Billing Phone #

Mailing Address		Additional Practice Location	
City	State Zip	City	State Zip
County	Phone #	County	Phone #

***Please use additional form to list additional addresses.**

To ensure that we load your demographic information correctly in our system, please indicate how you will be completing the rendering provider and billing provider information. This is a requirement for all billing methods including electronic. *Please be sure to include any abbreviations or spaces in the last or middle initial (if used for billing). For example: if the provider's last name is O'Brien, indicate if you bill as O'Brien, O'brien, O Brien, etc.*

Rendering Provider's Name	**Billing Name & Address**
_____	_____ _____ _____

Contact Information		
Credentialing Contact or Office Contact/Manager	E-Mail Address	
Phone #	Fax #	Date

*If submitting this form along with a contract you must mail the data sheet and original contract.
*Please make sure CAQH is complete & current, incomplete applications will cause a delay in credentialing.

Print Form

Please fax the completed form along with W-9 to (317) 573-2799 or mail to:
Sagamore Health Network, Inc.
Attn: Network Development
11595 North Meridian Street, Ste. 600
Carmel, IN 46032