CareSource™

NON-PAR PROVIDER PROFILE

Please complete this form for the provider listed on the attached claim; CareSource is unable to process the claim without this information. Please note that this document is for claims processing purposes only, and does not guarantee claims payment.

Provider Name and Credentials: _____

Medical License #: _____ DEA #: _____ NPI:_____

Primary Specialty: _____ Board Certified? ☐Yes ☐ No Board Eligible? ☐Yes ☐ No

Secondary Specialty: _____ Board Certified? ☐Yes ☐ No Board Eligible? ☐ Yes ☐ No

1) **Primary** Practice Name: _____ Medicaid ID #:_____

Address: _____

City: _____ State: _____ ZIP: _____

Phone #: _____ Fax #: _____ Federal Tax ID #: _____

Name of entity reimbursement is to be made payable to: _____ Entity's NPI:_____

Billing Address: _____

City: _____ State: _____ ZIP: _____

Billing Phone #:_____ Billing Fax #: _____ Contact Person:_____

All other correspondence should be mailed to: ☐ Practice ☐ Billing ☐ Other: _____

2) **Secondary** Practice Name: _____ Medicaid ID #:_____

Address:_____

City: _____ State: _____ ZIP: _____

Phone #: _____ Fax #: _____ Federal Tax ID #: _____

Name of entity reimbursement is to be made payable to: _____ Entity's NPI:_____

Billing Address: _____

City:_____ State: _____ ZIP: _____

Billing Phone #: _____ Billing Fax #: _____ Contact Person:_____

All other correspondence should be mailed to: ☐ Practice ☐ Billing ☐ Other: _____

NOTE: PLEASE ATTACH A W-9 FORM FOR THE TAX IDENTIFICATION NUMBER LISTED ON THIS FORM.

Attention: Provider Operations, P.O. Box 4135, Dayton, OH 45401-4135
Phone: 1-800-488-0134 ■ Fax: (937) 531-3910