



Provider Data Form

For Credentialing Purposes

Buckeye Community Health Plan (Buckeye) participates with the Council for Affordable Quality Healthcare (CAQH). Buckeye utilizes the CAQH Credentialing application mandated by Ohio House Bill 125. Please check the box below that applies to your situation:

I would prefer to send in a paper application to Buckeye.

If you are not registered with CAQH and do **not** wish to enroll with CAQH, please complete the CAQH Credentialing Form and return it via certified mail receipt to Buckeye Community Health Plan, Attention: Contracting Department, 175 S. 3rd St., Suite 1200, Columbus, Ohio 43215, or fax to 866-719-5441 along with this form.

I would like to join CAQH.

If you are not registered and would like to enroll with CAQH, please complete the information below so Buckeye can register you with CAQH. You will be notified once your CAQH ID number has been generated so you can proceed to <https://upd.caqh.org/oas/> to begin the application process. **Please ensure you complete your application with CAQH within 30 days of receiving your CAQH ID number to prevent further delay in the credentialing process.**

I am registered with CAQH.

If you are registered with CAQH, please complete the information below so Buckeye can retrieve your credentialing application from CAQH. **Please ensure that you have authorized Buckeye Community Health Plan to access your data or have granted global access for all health plans.**

****If you have already completed your CAQH application, please be sure that your information is current and has been verified within the past 90 days.**

Have you ever participated with Buckeye: <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes list the tax id(s) you currently or previously participated under:		Please include a letter of termination on company letterhead with the approximate term date for any prior par affiliations with Buckeye.	
Date:		CAQH Provider ID, if already enrolled:		SSN:	
Last Name:		First Name:		Middle:	Date of Birth:
State License Number:		Licensed State:		DEA Number:	
Primary Office Street Address:				Suite #:	
Primary Office City, State, Zip:				County:	
Primary Office Phone:			Primary Office Fax:		
Secondary Office Address:					
Third Office Address:					
Email address & fax number for credentialing contact:		Tax ID:		OH Medicaid No.:	
Provider Type/Degree (MD, DO, etc) :		Hospital Based and practice exclusively in an inpatient setting: <input type="checkbox"/> Yes <input type="checkbox"/> No		NPI	
Specialty(s):		Applying As: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Non-PCP (Normal PCP specialty i.e. Internal Med, etc that does not wish to be in the directory)			
<u>Please attach copies of the following documents and submit with this form, or we cannot go forward with the credentialing process:</u> <input type="checkbox"/> CLIA Certificate/Waiver for each office location, if applicable <input type="checkbox"/> W-9					
<input type="checkbox"/> <u>List of additional office locations other than what is listed above.</u>					

Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with Buckeye Community Health Plan. If you have any questions about CAQH, please contact the CAQH Help Desk at 1-888-599-1771.

Please fax this document to: Attn: Contracting at 866-719-5441 **OR** mail to: Buckeye Community Health Plan, Attn: Contracting 175 S. 3rd St, Ste. 1200 Columbus, Ohio 43215, along with supporting documents and the CAQH credentialing application if you are not currently on CAQH or in the process of joining CAQH.