CAQH Provider Data Form

To begin the credentialing process, please use this simple standardized form. This form represents your intent to join Gateway's network of providers.

Today's Date: ______________________________

Last Name:	First Name:	Middle Initial: Degree: (MD, DO,etc)
Date of Birth:	CAQH Provider Number:	Specialty:
License No.	NPI No: Individual Group	Tax ID:

____
Practice Name

____
Credentialing Contact and Phone Number

____
Address

____
E-Mail Address

____
Billing Address

____
Billing Phone Number

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