

New Provider Enrollment Form Attachment A/B

Please attach a W9 and return by email to OhioContracting@Centene.com Or use the submit button at the bottom of this page.

Buckeye Health Plan requires all providers to utilize CAQH for credentialing. If you do not utilize the Global Authorization option in CAQH, it is critical that you grant BHP authorization to access your data.

If more than 5 providers or 5 locations are in a group a Roster will be accepted containing the same information. If additional space is needed, or all the below information cannot be provided in a single document, please submit a separate form.

<u> </u>	211 tille 2010 til 111 oli 111 dillet 2011 110 til 20 pi 01		,	e e e	a o o p a : a c o : o :			
•	ne Provider Data Form (page 1) for each i							
	on pages 2-6. Please complete one Loca				tion for the provider.			
How many location	as does the provider work at under this ti							
		Information						
Credentialing Conta		Credentialing Phone						
Credentialing E-ma		Credentialing Fax N	umber:					
Curren Name a	Group I	nformation						
Group Name:		Group NPI:						
Group Tax ID Numb								
Billing Office Addre	ess:	T		ı				
Billing Office City:		State:		Zip:				
Billing Office Phone		Billing Office Phone	Fax:					
		Information		I				
Provider First Name	e:	Middle Name:		Last Na	me:			
Provider DOB:		Provider SSN:						
OH Medicaid Numb	per:	DEA Number:						
State License Numb	per:	Licensed State:						
Individual NPI#:		Provider Type: (MD, DO, etc.):						
Primary Specialty:		Secondary Specialty						
	(7)	Work in a Federally	Qualified H	ealth Cer	nter for this Tax ID: 🧑			
Applying as:	PCP Specialist	Yes	No		O			
Hospital Based and	practice exclusively in an inpatient setting	ng: Yes	No					
Is provider accepting	ng new patients:	Yes	No					
Does the provider h	nave any gender limitation on patients?	Yes	No	Gender	Limits:			
Does the provider h	nave any Age limitations on patients?	Yes	No	Age Lim	its:			
Is Provider Affiliate	d with a PHO: 7	Yes	No					
Is provider register	ed with CAQH: Yes No	If Yes, CAQH Provid	er ID:					
Please list any non-	English languages spoken by provider:							
Has provider receiv	ved any Cultural Competency Training:	Yes	No					
Please list if Cultura	al Training includes any	African American	American Indian Hispanic/Lati		Hispanic/Latino			
of the following:		Alaskan Native	Asian		Pacific Islander			
		Deafness	HIV/AIDS		Chronic Illness			
Please list Specializ	ed Training completed:	Blindness	•					
·		Serious Mental Illne	ess		·			
	Sig	nature						
Date:								
Typed Name:								

All fields on this form are required. If information does not apply please indicate N/A in the space provided.

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Location 1

Please complet	te a Location Fo	orm for each	Practice Location	l .								
Group Name:												
Practice Locat	ion Name:			Group Tax ID N	lumber:							
Primary Office		Direction	Street Name					Suffix	Suite			
Address:	300000	5	on eet Hame					Julia	Juice			
Primary Office	· Citv·			State:	Zip:		County:					
	Phone Numbe	ir.		Primary Office		her.	county.					
List this addre		PCP:	If DCD, would	you like to have			and to the	Capaci	itv			
in BHP Directo		Yes No	doctor or to	•	membe	ı s assığı	ied to the	Capaci	ity.			
III BITE DIFECTO	·				Fui:	Ja.,	Caturdan	C				
	Monday	Tuesday	Wednesday	Thursday	Fric	aay	Saturday	y Sunday				
Office		_		_	_				_			
Office	То	То	То	То	Т	0	То		То			
Hours												
	Closed	Closed	Closed	Closed	Clo		Closed		osed			
	Open 24 Hrs	Open 24 H	rs Open 24 Hrs	Open 24 Hrs	Oper	n 24 Hrs	Open 24 H	rs Ope	en 24 Hrs			
Does the locat	tion have acces	s to Language	e Line Services?				Yes	No				
Does the locat	tion offer transl	lation service	s for written mate	erials?			Yes	No				
Does the locat	tion offer non-E	nglish langua	ages, either spoke	n by the provide	r, office		Yes	No				
		-	dical interpreters?									
If above quest	ion is ves, pleas	se list which	non-English langu	ages are								
provided at th	• • •		0 0	J								
<u> </u>			ADA Ir	nformation								
Does your office	e meet ADA Park	ing Recomme	ndations, Including		ua.							
-		_	king (1 in 25 or 10%		_	neonle wi	ith					
mobility disabil		таптапар, рапт						Yes	No			
		essible availabl	le in your parking lo	ot.								
-An access aisle	next to each ma	irked space.										
Does your office	e meet Restroon	n Recommend	ations, Including Al	L of the following:	:							
-Restroom large	e enough to acco	mmodate a pa	atient who uses an	adult wheelchair o	r scooter	•						
-			36" wide, and easy	to open.								
	or stall have a m							Yes	No			
	toilet seat 17-19											
	nd and to the wa											
	en space (at leas	•										
	owel dispensers		ndations, Including	All of the followin								
•			ssible route (no less		_	rv door s	nt 37"					
			lear approach next			-		Yes	No			
wheelchair.	Tierra Timinina C	,, 30° 2, 10° 0	rear approach next	to all examination	tubic for	transier		103	110			
	trained to assist	with transfers	s on/off of examina	tion table.								
			dations, Including A		g:							
-Access to a wh	eelchair scale.							Yes	No			
-Access to a height adjustable exam table.												
			ns, Including ALL o					Yes	No			
			n and slip resistant		de.			103	110			
			ions, Including ALL	_								
			re a ramp or lift or		tive acces	ssible ent	rance.					
			ad or easy assist sy		had .		-4	Yes	No			
			care control button	_								
-		_	I" from the floor, w	_	-	o and dov	WII					
direction or ver	vai enunciators a	and doors and	cabs with the appr	opilate ullilelision	5.	D:		Yes	No			
Is the provider's	s location on an a	accessible pub	lic transportation re	oute?	-	Bus						
Is the provider's location on an accessible public transportation route? Train Yes							res	No				



Location 2

Please complete a Location Form for each Practice Location

Please complet	le a Location Fo	orm for each	Practice Location	•								
Group Name:												
Practice Locat	ion Name:			Group Tax ID N	umber:							
Primary Office		Direction	Street Name					Suffix	Suite			
Address:	30000000	Zii eetioii	Street Hame					Julia	Jane			
Primary Office	City			State:	Zip:		County:					
	Phone Numbe	r·		Primary Office I		nhor:	County.					
List this addre		PCP:	If DCD, would				ad to the	Canaci	itur			
!		Yes No	doctor or to t	you like to have	тетье	rs assign	ed to the	Capaci	ty.			
in BHP Directo						1.	Saturday					
	Monday	Tuesday	Wednesday	Thursday	Fric	aay	nday					
O.C.	_	_	_	_								
Office	То	То	То	То	Т	To To To						
Hours												
	Closed	Closed	Closed	Closed		sed	Closed		osed			
	Open 24 Hrs	Open 24 Hi	rs Open 24 Hrs	Open 24 Hrs	Oper	n 24 Hrs	Open 24 Hr	s Ope	en 24 Hrs			
Does the locat	tion have access	s to Language	Line Services?				Yes	No				
Does the locat	tion offer transl	ation service	s for written mate	erials?			Yes	No				
Does the locat	tion offer non-E	nglish langua	iges, either spoke	n by the provider	, office		Yes	No				
			ical interpreters?									
If above quest	ion is ves, pleas	se list which r	non-English langua	ages are								
provided at th			0 0									
<u> </u>			ADA In	formation								
Does your office	e meet ADA Park	ing Recomme	ndations, Including		ng:							
-		_	ing (1 in 25 or 10%		_	people wi	th					
mobility disabil		, , , , , , , , , , , , , , , , , , , ,		p,				Yes	No			
-		ssible availabl	e in your parking lo	t.								
-An access aisle	next to each ma	rked space.										
Does your office	e meet Restroom	n Recommenda	ations, Including AL	L of the following:								
_	_	•	itient who uses an a		scooter							
			36" wide, and easy	to open.								
	or stall have a m							Yes	No			
	toilet seat 17-19											
	nd and to the wa											
-	oen space (at leas											
	owel dispensers		m the noor. ndations, Including A	ALL of the following	a.							
			ssible route (no less		_	ry door a	ıt 32"					
			ear approach next			-		Yes	No			
wheelchair.	in a minimum o	71 30 By 40 Ci	car approach fiexe	to an examination	table for	cransici	nom a	163	110			
	trained to assist	with transfers	on/off of examinat	ion table.								
			dations, Including A		;:							
-Access to a wh			,	9				Yes	No			
-Access to a hei	ght adjustable ex	kam table.										
Does your office meet Route Recommendations, Including ALL of the following:								Yes	No			
-The route of tr	avel to the buildi	ng stable, firm	and slip resistant a	ınd at least 36" wic	de.			163	INU			
			ons, Including ALL o	_								
			re a ramp or lift or i		ive acces	ssible ent	rance.					
			ad or easy assist sys					Yes	No			
			care control buttor	-								
-		_	" from the floor, wi	_	-	o and dov	vn					
unection or ver	vai enunciators a	and doors and	cabs with the appro	philate diffiensions	·.			Voc	NI.O.			
Is the provider's	s location on an a	accessible publ	lic transportation ro	oute?	-	Bus		Yes	No			
1		•	•			Train		Yes	No			

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Location 3

Please complete a Location Form for each Practice Location

Please complet	le a Location Fo	orm for each	Practice Location	•									
Group Name:													
Practice Locat	ion Name:			Group Tax ID N	umber:								
Primary Office		Direction	Street Name	Croup rux is it	umben			Suffix	Suite				
Address:	Street No	Direction	Street Name					Julia	Juice				
Primary Office	City			State:	7in.		Country						
	•				Zip:		County:						
•	Phone Numbe		11.000 11	Primary Office I			11						
List this addre		PCP:		you like to have	membe	ers assign	ed to the	Capaci	ity:				
in BHP Directo		Yes No	doctor or to t										
	Monday	Tuesday	Wednesday	Thursday	Frie	Friday Saturday S							
Office	То	То	То	То	7	ō	То	Го То					
Hours													
	Closed	Closed	Closed	Closed	Clo	sed	Closed	Cl	osed				
	Open 24 Hrs	Open 24 Hi	rs Open 24 Hrs	Open 24 Hrs	Ope	n 24 Hrs	Open 24 Hı	s Ope	en 24 Hrs				
Does the locat	tion have access	s to Language	Line Services?				Yes	No					
			s for written mate	erials?			Yes	No					
			iges, either spoke		office		Yes	No					
			lical interpreters?		, office		103	140					
<u>'</u>		•	non-English langu										
provided at th		se list willer i	ion-Liigiisii iangu	ages are									
provided at th	iis iocation.		ADA I	.f									
				formation									
-		_	ndations, Including		_		*I-						
		iandicap) park	ing (1 in 25 or 10%	or total spaces) tha	at serve	peopie wi	tn	Vaa	Na				
mobility disabil		scible availabl	e in your parking lo	+				Yes	No				
-	next to each ma		e iii your parkiiig io	ι.									
			ations, Including AL	L of the following:									
-			itient who uses an a	_	rscooter								
_	_	•	36" wide, and easy										
	or stall have a m			·				Yes	No				
	toilet seat 17-19												
-Grab bars behi	nd and to the wa	all side of the t	oilet.										
-At least one op	en space (at leas	st 42") to the s	ide of the toilet.										
	owel dispensers												
			ndations, Including		_								
			ssible route (no less	·		-							
	ith a minimum o	of 30" by 48" cl	ear approach next	to an examination	table for	r transfer	from a	Yes	No				
wheelchair.			/	Van table									
			on/off of examinat										
-Access to a wh		nt kecommen	dations, Including A	LL of the following	; :			Yes	No				
		vam tahla						103	110				
-Access to a height adjustable exam table. Does your office meet Route Recommendations, Including ALL of the following:													
			and slip resistant a		de			Yes	No				
			ons, Including ALL o		ис.								
			re a ramp or lift or i	_	ive acce	ssible ent	rance.						
			ad or easy assist sys					Yes	No				
			care control buttor		both rai	sed chara	cters						
			" from the floor, wi	_									
direction or ver	bal enunciators a	and doors and	cabs with the appro	opriate dimensions	5								
						Bus		Yes	No				
Is the provider's location on an accessible public transportation route?								Yes	No				

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Location 4

Please complete a Location Form for each Practice Location

Please complet	te a Location Fo	orm for each	Practice Location	•									
Group Name:													
Practice Locat	ion Name:			Group Tax ID N	umber:								
Primary Office		Direction	Street Name	Croup rux is it	umben			Suffix	Suite				
Address:	Street No	Direction	Street Name					Julia	Juice				
Primary Office	City			State:	7in:		Country						
	•			-	Zip:	ا ما ما ما	County:						
•	Phone Numbe		16 000 11	Primary Office			1						
List this addre		PCP:		you like to have	membe	ers assign	ed to the	Capaci	ty:				
in BHP Directo	1	Yes No	doctor or to t										
	Monday	Tuesday	Wednesday	Thursday	Frie	Friday Saturday S							
Office	То	То	То	То	7	ō	То	о То					
Hours													
	Closed	Closed	Closed	Closed	Clo	sed	Closed	Clo	osed				
	Open 24 Hrs	Open 24 H	rs Open 24 Hrs	Open 24 Hrs	Ope	n 24 Hrs	Open 24 Hr	s Ope	en 24 Hrs				
Does the locat	tion have access	s to Language	Line Services?				Yes	No					
			s for written mate	erials?			Yes	No					
			iges, either spoke		office		Yes	No					
			lical interpreters?		, ornec		163	110					
<u>'</u>		•	non-English langu										
provided at th		se list willer i	ion-English langu	ages are				_					
provided at th	iis iocation.		4 D A 1	.faatia									
D (f)				formation									
-		_	ndations, Including		_		al-						
mobility disabil		iandicap) park	ing (1 in 25 or 10%	or total spaces) tha	at serve	people wi	tn	Yes	No				
-		ssihle availahl	e in your parking lo	+				163	NO				
-	next to each ma		e iii your parking io	ι.									
			ations, Including AL	L of the following:									
-			itient who uses an a	_	rscooter								
_	-		36" wide, and easy										
	r or stall have a m			·				Yes	No				
	toilet seat 17-19												
-Grab bars behi	ind and to the wa	all side of the t	oilet.										
-At least one op	oen space (at leas	st 42") to the s	ide of the toilet.										
	owel dispensers												
			ndations, Including		_								
			ssible route (no less			-							
	vith a minimum o	of 30" by 48" cl	ear approach next	to an examination	table for	r transfer	trom a	Yes	No				
wheelchair.	trained to assist	with transford	on laft of avaminat	tion table									
			on/off of examinated ations, Including A										
		iit kecommen	dations, including A	LL of the following	·			Yes	No				
-Access to a wheelchair scaleAccess to a height adjustable exam table.								103	110				
Does your office meet Route Recommendations, Including ALL of the following:													
			and slip resistant a		de.			Yes	No				
			ons, Including ALL										
			re a ramp or lift or i	_	ive acce	ssible ent	rance.						
			ad or easy assist sys					Yes	No				
			care control buttor		both rai	sed chara	cters						
-		_	" from the floor, wi	_		p and dov	vn						
direction or ver	bal enunciators a	and doors and	cabs with the appro	opriate dimensions	S								
اد دام معمد الطاء ال	clocation carac	accoccible mid-	lic transpartation	vu+o2		Bus		Yes	No				
Is the provider's location on an accessible public transportation route?								Yes	No				

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Location 5

Please complete a Location Form for each Practice Location.

Group Name:	ic a Location i	or caeri	Tractice Location	•								
<u>'</u>	·			C T. ID N								
Practice Locat		1		Group Tax ID N	umber:				1			
Primary Office Address:	Street No	Direction	Street Name					Suffix	Suite			
Primary Office	City:			State:	Zip:		County:		- V			
•	Phone Numbe	er:		Primary Office	•	nber:	,					
List this addre		PCP:	If PCP, would	you like to have			ed to the	Capac	itv:			
in BHP Directo		Yes No	doctor or to t	-		. 5 455.6.	ica to the	Capac	,.			
m Bin Birecte	Monday	Tuesday	Wednesday	Thursday	Fric	lav	Saturday	Sı	ınday			
	Williady	racsaay	vvcancsaay	Illuisaay	1110	iay	Saturday	30	illuay			
Office	То	То	То	То	Т	0	То	То				
Hours	10	10	10	10	'	U	10		10			
110013	Cl I	GI I	Cl l	Classic	CI.	1	Cl l		1			
	Closed	Closed	Closed	Closed	Clo		Closed	-	osed			
	Open 24 Hrs	Open 24 H	·	Open 24 Hrs	Oper	n 24 Hrs	Open 24 H		en 24 Hrs			
			e Line Services?				Yes	No				
Does the locat	ion offer transl	lation service	s for written mate	erials?			Yes	No				
Does the locat	ion offer non-E	English langua	ages, either spoke	n by the provide	r, office		Yes	No				
personnel or c	offered onsite b	y skilled med	lical interpreters?									
If above quest	ion is yes, pleas	se list which	non-English langua	ages are								
provided at th	is location:											
			ADA In	formation								
Does your office	e meet ADA Park	ing Recomme	ndations, Including		ng:							
			ing (1 in 25 or 10%			people wi	ith					
mobility disabili		.,,	5 (, ,		•		Yes	No			
-At least 1 space	e that is van acce	essible availabl	e in your parking lo	t.								
-An access aisle	next to each ma	irked space.										
Does your office	e meet Restroon	n Recommend	ations, Including AL	L of the following:								
			atient who uses an a		r scooter							
			36" wide, and easy	to open.								
	or stall have a m							Yes	No			
<u> </u>	toilet seat 17-19											
	nd and to the wa											
•	en space (at leas	•										
·	owel dispensers		m the floor. Including A	All of the followin	~.							
·=			ssible route (no less		_	ry door a	u+ 27"					
			lear approach next t					Yes	No			
wheelchair.	ntir a miniminam c	71 30 by 40 c	icai approacii iicat i	to all examination	table for	transici	nom a	103	110			
	trained to assist	with transfers	on/off of examinat	tion table.								
			dations, Including A		ξ:							
-Access to a wh			,					Yes	No			
-Access to a hei	ght adjustable ex	xam table.										
Does your office meet Route Recommendations, Including ALL of the following:							Vaa	Na				
-The route of travel to the building stable, firm and slip resistant and at least 36" wide.								Yes	No			
Does your office	e meet Interior R	Recommendati	ons, Including ALL o	of the following:								
			re a ramp or lift or i		ive acces	ssible ent	rance.					
			ad or easy assist sys					Yes	No			
			care control button									
-		_	" from the floor, wi	_	-	and dov	wn					
direction or ver	bal enunciators a	and doors and	cabs with the appro	opriate dimensions	S.							
Is the provider's	s location on an a	accessible nub	lic transportation ro	oute?		Bus		Yes	No			
.s the provider s	Journall off all (accessione pub	cransportation re			Train		Yes	No			

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