

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.

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	Please complete one Provider Data Form (page 1) for each new provider in the practice.						
Location Forms are on pages 2-6. Please complete one Location Form (pages 2-6) for each office location for the provide							
How many locations d	does the provider work at under this tir		Date Comple	eting:			
		Information					
Credentialing Contact:	:		<u>Phone Number:</u>				
Credentialing E-mail:		Credentialing F	ax Number:				
	Group I	nformation					
Group Name:		Group NPI:					
Group Tax ID Number:	:						
Billing Office Address:							
Billing Office City:		State:		Zip:			
Billing Office Phone No	umber:	Billing Office Pl	none Fax:				
	Provider	Information					
Provider First Name:		Middle:	Last Name:				
Provider DOB:		Provider SSN:					
OH Medicaid Number:	:	DEA Number:					
State License Number:	:	Licensed State:					
Individual NPI#:		Provider Type: (MD, DO, etc.):					
Primary Specialty:		Secondary Spe	cialty:				
Applying PCP	Behavioral Health Only	Work in a Fede	rally Qualified H	lealth Cer	nter for this Tax ID:		
as: Specialis	st Behavioral Health and Medical	Yes	No				
Hospital Based and pra	ractice exclusively in an inpatient settin	ıg: Yes	No				
Is provider accepting r	new patients:	Yes	No				
Does the provider hav	ve any gender limitation on patients?	Yes	No	Gender	Limits:		
Does the provider hav	ve any Age limitations on patients?	Yes	No	Age Lim	its:		
Is Provider Affiliated w	with a PHO:	Yes	No				
Is provider registered	with CAQH: Yes No	If Yes, CAQH Pr	ovider ID:				
Please list any non-Eng	glish languages spoken by provider:						
Has provider received	l any Cultural Competency Training:	Yes	No				
Please list if Cultural T	Fraining includes any	African Americ	an Americar	Indian	Hispanic/Latino		
of the following:	Alaskan Native	Asian		Pacific Islander			
Please list Specialized	Training completed:	Deafness	HIV/AIDS	ı	Chronic Illness		
·	oviders must complete	Blindness	Homeless	sness	Physical Disabilities		
Section C at the end o	·	Serious Mental	Illness				
	Sign	nature					
Date:							
Typed Name:							

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



Location 1

Please complete a Location Form for each Practice Location

riease complet	le a Location Fo	iiii ioi eacii	Practice Location						
Group Name:									
Practice Locat	ion Name:			Group Tax ID N	umber:				
Primary Office		Direction	Street Name	Group rax is it.	arriber.			Suffix	Suite
Address:	Street No	Direction	Street Name					Julia	Jane
Primary Office	· Citv·			State:	Zip:		County:		
•	Phone Numbe	r·		Primary Office F	-	nher [.]	county.		
Triiilary Office	Thore Nambe	1 •		Triillary Office I	ax ivai	iibei.			
PCP: Yes	No		Capacity:						
	Monday	Tuesday	Wednesday	Thursday	Fri	day	Saturday	Sui	nday
	,			,					<u>-</u>
Office	То	То	То	To To To To					
Hours	10	10	10	10			10		
	Closed	Closed	Closed	Closed	Clo	sed	Closed	Cla	sed
	Open 24 Hrs	Open 24 H	+	Open 24 Hrs		n 24 Hrs	Open 24 Hrs		n 24 Hrs
Doos the least		•		Open 24 1113	Орс	11 24 1113	•	1	11 24 1113
			e Line Services? s for written mate	ا ا ا ا ا			Yes	No	
					. cc.		Yes	No	
			ages, either spoke		, office		Yes	No	
•		•	lical interpreters?					1	
•		se list which i	non-English langua	ages are					
provided at th	iis location:			_					
Γ				formation					
-		_	ndations, Including		_				
· ·	•	iandicap) park	ing (1 in 25 or 10% o	of total spaces) tha	it serve	people wi	th	.,	
mobility disabil		اطمانوريو واطنوو		_				Yes	No
-			e in your parking lo	τ.					
	next to each ma		ations, Including AL	L of the following:					
-			ations, including AL atient who uses an a	_	scooter	-			
_	_		36" wide, and easy		3000101	•			
	r or stall have a m			то оро				Yes	No
	toilet seat 17-19'								
	ind and to the wa								
-At least one op	oen space (at leas	t 42") to the s	ide of the toilet.						
-The soap and t	owel dispensers	48" or less fro	m the floor.						
Does your offic	e meet Exam Roc	m Recommer	ndations, Including A	ALL of the following	g:				
			ssible route (no less	·		-			
	vith a minimum o	f 30" by 48" c	lear approach next t	to an examination	table foi	r transfer	from a	Yes	No
wheelchair.			/						
			on/off of examinat						
-Access to a wh		it kecommen	dations, Including A	LL of the following	:			Yes	No
	ight adjustable ex	am tahle						103	110
			ns, Including ALL of	the following:					
			and slip resistant a		le.			Yes	No
			ions, Including ALL o						
· ·			re a ramp or lift or i	_	ive acce	ssible ent	rance.		
			ad or easy assist sys					Yes	No
-Elevators locat	ed on an accessib	ole route with	care control button	s designated with	both rai	sed chara	cters		
-		_	" from the floor, wi	_		p and dov	vn		
direction or ver	bal enunciators a	ind doors and	cabs with the appro	opriate dimensions					
Is the provider!	s location on an a	occassible aub	lic transportation ==	uuto?		Bus		Yes	No
is the provider:	Is the provider's location on an accessible public transportation route? Train Yes No								No

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Location 2

Please complete a Location Form for each Practice Location.

r rease complet	ic a Location i c	min for cacif	Tractice Location	•						
Group Name:										
Practice Locat	ion Name:			Group Tax ID N	umber:					
Primary Office		Direction	Street Name	Group rux is it	41110011			Suffix	Suite	
Address:	Street No	Birection	Street Name					Julia	Juice	
	City			State:	Zip:		Country			
Primary Office	•				•		County:			
Primary Office	Phone Numbe	Γ.		Primary Office	rax ivuiii.	er:				
PCP: Yes	No		Capacity:							
	Monday	Tuesday	Wednesday	Thursday	Frida	IV	Saturday	Su	nday	
		,		·						
Office	То	То	То	То	То		То		То	
Hours	10	10	10	10	10		10		10	
	Closed	Closed	Closed	Closed	Close	.d	Closed	Cl	osed	
	Open 24 Hrs	Open 24 Hi		Open 24 Hrs	Open 2		Open 24 Hrs		n 24 Hrs	
5	·	·		Орен 24 нгз	Open 2	24 ПІЗ	-	-	24 113	
	tion have access						Yes	No		
			s for written mate				Yes	No		
		-	iges, either spokei	n by the provide	r, office		Yes	No		
		•	ical interpreters?							
If above quest	ion is yes, pleas	se list which r	non-English langua	ages are						
provided at th	is location:									
			ADA In	formation						
Does your office	e meet ADA Park	ing Recomme	ndations, Including	ALL of the followin	ng:					
-Adequate, mar	ked accessible (h	nandicap) park	ing (1 in 25 or 10% o	of total spaces) tha	at serve pe	ople wi	ith			
mobility disabil	ities.							Yes	No	
			e in your parking lot	t.						
-An access aisle	next to each ma	rked space.								
-			ations, Including AL I	_						
_	_	•	itient who uses an a		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 A	ALL of the followin	α.					
-			sible route (no less		_	, door a	nt 32"			
			ear approach next t	•				Yes	No	
wheelchair.		. 30 2, 10 0.	car approach next	o arr examination	table for th	ansici		. 65	110	
	trained to assist	with transfers	on/off of examinat	ion table.						
			dations, Including A		ζ:					
-Access to a wh	eelchair scale.							Yes	No	
-Access to a hei	ght adjustable ex	kam table.								
Does your office	e meet Route Re	commendatio	ns, Including ALL of	the following:				Yes	No	
-The route of tr	avel to the buildi	ng stable, firm	and slip resistant a	nd at least 36" wid	de.			163	NO	
			ons, Including ALL o	_						
-If there are stairs at the main entrance, is there a ramp or lift or is there an alternative accessible entrance.										
-An entry door at least 34" wide with a push pad or easy assist systemElevators located on an accessible route with care control buttons designated with both raised characters						No				
			" from the floor, with			and dov	wn			
direction or ver	vai enunciators a	and doors and	cabs with the appro	priate dimensions	s. 			Vos	No	
Is the provider's	s location on an a	accessible publ	ic transportation ro	oute?	<u> </u>	Bus		Yes	No	
Train						No				

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Location 3

Please complete a Location Form for each Practice Location.

ricase complet	c a Location i c	ATTITION CACIT	Tractice Location	•					
Group Name:									
Practice Locat	ion Name:			Group Tax ID N	lumber:				
Primary Office		Direction	Street Name					Suffix	Suite
Address:	Street No	2	Street Hame					Julia	Jane
Primary Office	City			State:	Zip:		County:		
•	Phone Numbe	r·		Primary Office		har:	County.		
Triillary Office	r none numbe	1.		Triinary Office	I ax Ivuiii	DEI.			
PCP: Yes	No		Capacity:						
	Monday	Tuesday	Wednesday	Thursday	Frida	av	Saturday	Su	nday
		- racoua,	- Troumcoudy						
Office	То	То	То	То	To)	То		То
Hours	10	10	10	10		<u>′</u>	10		
110013	Closed	Closed	Closed	Closed	Clos	od	Closed	Cl	osed
	Open 24 Hrs	Open 24 H		Open 24 Hrs		24 Hrs	Open 24 Hr		en 24 Hrs
5	·	·		Орен 24 нгз	Open	24 ПІЗ			24 ПІЗ
	tion have access						Yes	No	
			s for written mate				Yes	No	
		-	ages, either spoke	n by the provide	r, office		Yes	No	
		•	lical interpreters?		ı		T	1	
		se list which i	non-English langua	ages are					
provided at th	is location:								
			ADA In	formation					
Does your office	e meet ADA Park	ing Recomme	ndations, Including	ALL of the following	ng:				
-Adequate, mar	ked accessible (h	nandicap) park	ing (1 in 25 or 10% o	of total spaces) tha	at serve pe	eople w	ith		
mobility disabil	ities.							Yes	No
			e in your parking lo	t.					
	next to each ma								
-			ations, Including AL	_					
_	_	-	ntient who uses an a		r 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 cowel dispensers								
	•		ndations, Including A	ALL of the followin	ıα.				
-			ssible route (no less		_	v door a	at 32"		
			lear approach next t	·		-		Yes	No
wheelchair.		,							
-Staff members	trained to assist	with transfers	on/off of examinat	ion table.					
Does your office	e meet Equipme i	nt Recommen	dations, Including A	LL of the following	g:				
-Access to a wh								Yes	No
-Access to a height adjustable exam table.									
-	Does your office meet Route Recommendations, Including ALL of the following: Yes No							No	
			and slip resistant a		de.				
· ·			ons, Including ALL o	_	Lt				
-If there are stairs at the main entrance, is there a ramp or lift or is there an alternative accessible entrance.									
-An entry door at least 34" wide with a push pad or easy assist systemElevators located on an accessible route with care control buttons designated with both raised characters						No			
and Braille symbols that are no higher than 54" from the floor, with audible signals for the up and down direction or verbal enunciators and doors and cabs with the appropriate dimensions.									
3 2321311 01 VCI			and the appro			Bus		Yes	No
Is the provider's	s location on an a	accessible pub	lic transportation ro	oute?				Yes	No
1	Train Yes No								

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Location 4

Please complete a Location Form for each Practice Location.

Group Name:	c a Location re	orni for cacif	Tactice Location	•					
·	·								
Practice Locati	1			Group Tax ID N	umber:				
Primary Office Address:	Street No	Direction	Street Name					Suffix	Suite
Primary Office	Citv:			State:	Zip:		County:		
•	Phone Numbe	r:		Primary Office	•	ber:	Country		
PCP: Yes	No		Capacity:						
	Monday	Tuesday	Wednesday	Thursday	Frid	ay	Saturday	Sui	nday
	-	•				-	-		•
Office	То	То	То	То	To	0	То	-	Го
Hours		. •		. 0					. •
	Closed	Closed	Closed	Closed	Clos	- has	Closed	Cla	sed
	Open 24 Hrs	Open 24 Hr		Open 24 Hrs		24 Hrs	Open 24 Hrs		n 24 Hrs
Dana tha lanat		•		Open 24 ms	Open	1 24 1113		_1	11 24 1113
	ion have access						Yes	No	
			for written mate				Yes	No	
		-	ges, either spokei ical interpreters?	n by the provide	r, office		Yes	No	
•		•	on-English langua	iges are					
provided at th		oc not winen n	ion English langue	ages are					
provided at til	13 10 00 10 11.		ΔDΔ In	formation					
Doos your office	most ADA Daul e	ina Dosommon							
-		_	ndations, Including and the second se		_	نيد ماممه	;+h		
mobility disabili	-	iaiiuicap) parki	ing (1 iii 25 0i 10% (or total spaces) the	at serve p	eopie w	iui	Yes	No
-		ssihle availahle	e in your parking lot	-				163	INO
-	next to each ma		In your parking io	••					
		•	itions, Including AL	L of the following:					
-			tient who uses an a	_	r scooter.				
_	_		36" wide, and easy						
	or stall have a m			•				Yes	No
-The top of the	toilet seat 17-19	" from the floo	r.						
-Grab bars behi	nd and to the wa	II side of the to	oilet.						
· ·	en space (at leas								
	owel dispensers								
· ·			dations, Including A		_				
			sible route (no less			-			
	ith a minimum o	t 30" by 48" cl	ear approach next t	o an examination	table for	transfer	from a	Yes	No
wheelchair.			/- ff - f	in a kalala					
			on/off of examinat						
		nt kecommend	lations, Including A	LL of the following	3:			Yes	No
	Access to a Wilesianan State.								140
-Access to a height adjustable exam table. Does your office meet Route Recommendations, Including ALL of the following:									
•	-The route of travel to the building stable, firm and slip resistant and at least 36" wide. Yes No							No	
					ис.				
Does your office meet Interior Recommendations, Including ALL of the following: -If there are stairs at the main entrance, is there a ramp or lift or is there an alternative accessible entrance.									
							No		
-Elevators located on an accessible route with care control buttons designated with both raised characters									
and Braille symbols that are no higher than 54" from the floor, with audible signals for the up and down									
direction or verbal enunciators and doors and cabs with the appropriate dimensions.									
la Alaa						Bus		Yes	No
is the provider's	ovider's location on an accessible public transportation route? Train Yes							No	

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Location 5

Please complete a Location Form for each Practice Location.

r icase complet	hease complete a cocation form for each fractice cocation.								
Group Name:									
Practice Locat	ion Name			Group Tax ID N	umber:				
Primary Office		Direction	Street Name	Group Tax ID IV	uniber.			Suffix	Suite
Address:	Street No	Direction	Street Name					Sullix	Juite
	C:+			Chahai	7:		6		
Primary Office				State:	Zip:	l	County:		
Primary Office	Phone Numbe	r:		Primary Office	Fax Num	ber:			
PCP: Yes	No		Capacity:						
	Monday	Tuesday	Wednesday	Thursday	Frida	ay	Saturday	Su	nday
	-	•							
Office	То	То	То	То	To)	То		То
Hours						·			
	Closed	Closed	Closed	Closed	Clos	ed	Closed	Cl	osed
	Open 24 Hrs	Open 24 H		Open 24 Hrs		24 Hrs	Open 24 Hr		en 24 Hrs
Door the least	·	·		Open 24 1113	Орсп	241113			.11 24 1113
			E Line Services?				Yes	No	
			s for written mate		561		Yes	No	
		-	ages, either spoke	n by the providei	r, office		Yes	No	
		•	lical interpreters?	_			I		
		se list which i	non-English langua	ages are					
provided at th	is location:								
				formation					
-		_	ndations, Including		_				
· ·		nandicap) park	ing (1 in 25 or 10% o	of total spaces) tha	at serve pe	eople w	ith		
mobility disabil				_				Yes	No
			e in your parking lo	t.					
	next to each ma		ations Including All	L of the fellowing					
-			ations, Including AL atient who uses an a	_					
_	_	-	36" wide, and easy		i scoolei.				
	or stall have a m			то орст.				Yes	No
	toilet seat 17-19		-						110
-	nd and to the wa								
	en space (at leas								
	owel dispensers								
Does your office	e meet Exam Roc	m Recommer	ndations, Including A	ALL of the followin	g:				
			ssible route (no less	· ·		-			
	ith a minimum o	of 30" by 48" cl	lear approach next t	to an examination	table for t	ransfer	from a	Yes	No
wheelchair.									
			on/off of examinat						
		nt Recommen	dations, Including A	LL of the following	3:			Vac	No
	-Access to a wheelchair scale. Yes No							NO	
-Access to a height adjustable exam table. Does your office meet Route Recommendations, Including ALL of the following:									
•			nand slip resistant a	_	de			Yes	No
			ons, Including ALL o		ac.				
			_	_	tive access	sible ent	rance.		
-If there are stairs at the main entrance, is there a ramp or lift or is there an alternative accessible entrance. -An entry door at least 34" wide with a push pad or easy assist system. Yes No						No			
-Elevators located on an accessible route with care control buttons designated with both raised characters									
and Braille sym	bols that are no h	nigher than 54	" from the floor, wit	th audible signals f	for the up	and dov	wn		
direction or ver	direction or verbal enunciators and doors and cabs with the appropriate dimensions.								
المناطقين مطعما	o logotion an ar-	الماديم والمادودود	lio tropoportatia:- :	+		Bus		Yes	No
is the provider:	s the provider's location on an accessible public transportation route? Train Yes						No		

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Section C - Provider Specialty Profile

Treatment Expertise/Specialties

Please select the types of services you offer, including the disorders you treat and the modalities you practice. (Check those that apply)

NOTE: Please submit evidence of certificates or transcripts that account for the associated trainings in the treatment modalities and/or disorders selected below.

Certifications							
Art Therapy	Positive Behavior Support						
Center of Excellence	SBIRT						
Emergency Services Provider	Targeted Case Management (TCM) Certificate Required						
Lead Behavior Analysis Therapist	Trauma Informed Care						
Settings/Po	opulations Treated						
Adolescents	Homelessness						
Adults	Men						
Blind/Visually Impaired	Mobile Crisis						
Children	Nursing Home						
Community Based	Physical Disability						
Deaf/Hearing Impaired	Serious Emotional Disturbance						
Developmental Disability	Serious Mental Illness						
Emotionally Disturbed	Severe Persistent Mentally III						
Gay/Lesbian	School Based						
Geriatric	Telemedicine						
Hospital Based	Women						
Home Based	Young Children						
Treatment Mo	odalities/ Approaches						
Applied Behavioral Analysis (ABA)	Group Therapy						
Addictive Disorders	Geriatric Psychiatry						
Adolescent Psychotherapy	Gestalt						
Adolescent Sex Offender	Hypnosis						
Adolescent Psychiatry	Intensive Family Intervention						
Adoption Issues	Individual Therapy						
Alcohol/SA Treatment	Intensive Outpatient						
Anger Management	Intake Assessment						
Art Therapy	Medication Management						
Attachment Therapy	Methadone/Suboxone						
Behavioral Therapy	Mood Disorders						
Brief Therapy	Neuropsychological Testing						
Biofeedback	Neuro-Linguistic Programming (NLP)						
Chemical Dependency Assessment	Outcomes Oriented Therapy						
Child Parent Psychotherapy (CCP)	Parent Child Interaction Therapy (PCIT)						
Child Psychological Testing	Play Therapy						
Child Psychiatry	Psychological Testing						
Christian Counseling	Psychoanalytic Therapy						
Client Centered Therapy	Psychodynamic Therapy						
Cognitive Rehab Therapy	Psychopharmacology						

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Cognitive Therapy	Pain Management
Community Support Program	Rationale Emotive Therapy
Community Support Program for the homeless	Relapse Prevention
Couples Therapy	Relationship Disorders
Crisis Intervention/Stabilization	Sensory Processing/Integration
Critical Incident Debriefing	Sexual Compulsions/Addictions
Dialectical Behavioral Therapy	Sex Therapy
Developmental Evaluation	Solution Empowerment Therapy
Domestic Violence	Stress Management
ECT ECT	Tobacco
EMDR	Tobacco Cessation
Evaluation/Assessment	Trauma Focused Cognitive Behavioral Therapy
Family Therapy	Trauma Informed Care (TIC)
Family Systems	Trust Based Relational Intervention (TBRI)
Gay/Lesbian/Bisexual	Weight Management
	ders/Issues
Addictive Medicine	Impulse disorders
ADD/ADHD	Infertility
Addictive Disorders	Inpatient Attending
Adjustment Disorder	Inpatient Attending Inpatient Consult MD
Adolescent Behavior Disorders	Learning Disability
Adoption Issues	Medical Evaluation
Adult ADD	Medical Illness/Chronic Illness
AIDS/HIV	Men Issues
Anger Management	Mood Disorders
Anxiety/Panic Disorder	Marital Issues
Attachment Disorder	Mental Retardation
Autism/Asperger's	Obsessive Compulsive Disorder
Bipolar Disorders	Oppositional Defiant Disorder
Chemical Dependency	Organic Mental Disorder
Christian/Spiritual	Parenting Issues
Chronic Pain/Pain Management	Personality Disorders
Crisis Stabilization	Post-Partum Disorder
Cultural Issues	PTSD
Child/Parent Bonding	Panic Disorder
Co-occurring Disorders	Phobias
Cognitive Disorder	Physical Abuse
Concussion	Reactive Attachment Disorder
Criminal Offenders	Relapse Prevention
Dementia Disorders	Sexual/Physical Abuse (Adults)
Development Disorders	Sexual/Physical Abuse (Children)
Disruptive Behavior	Schizophrenia
Dissociative Disorder	Serious/Persistent Mental Illness
Separation/Divorce	Sexual Disorders
Domestic Violence	Sexual Dysfunction
Dual Diagnosis	Sexual Abuse/Incest
Depression	Sleep Disorder
Disabled	Step/Blended Families
	t

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Eating Disorders	Stress Management
Equine Assisted Therapies	Self-Injury
Family Dysfunction	Sexual Offender
Feeding Disorders	Substance Abuse
Gay/Lesbian/Bisexual	Suicide
Gender Identity Issues	Tobacco Cessation
Grief/Loss/Bereavement	Women Issues
Head Trauma	Work Related Problems
Home Visits	

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