



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.

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 provider.			
How many locations does the provider work at under this tin:		Date Completing:	
Contact Information			
Credentialing Contact:		Credentialing Phone Number:	
Credentialing E-mail:		Credentialing Fax Number:	
Group Information			
Group Name:		Group NPI:	
Group Tax ID Number:			
Billing Office Address:			
Billing Office City:		State:	Zip:
Billing Office Phone Number:		Billing Office Phone 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 Specialty:	
Applying as:	PCP Specialist	Behavioral Health Only Behavioral Health and Medical	Work in a Federally Qualified Health Center for this Tax ID: Yes No
Hospital Based and practice exclusively in an inpatient setting:		Yes	No
Is provider accepting new patients:		Yes	No
Does the provider have any gender limitation on patients?		Yes	No Gender Limits:
Does the provider have any Age limitations on patients?		Yes	No Age Limits:
Is Provider Affiliated with a PHO:		Yes	No
Is provider registered with CAQH:		Yes No	If Yes, CAQH Provider ID:
Please list any non-English languages spoken by provider:			
Has provider received any Cultural Competency Training:		Yes	No
Please list if Cultural Training includes any of the following:		African American Alaskan Native	American Indian Asian Hispanic/Latino Pacific Islander
Please list Specialized Training completed: (Behavioral Health Providers must complete Section C at the end of this form.)		Deafness Blindness Serious Mental Illness	HIV/AIDS Homelessness Chronic Illness Physical Disabilities
Signature			
Date:			
Typed Name:			

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

Provider Location Form

Location 1

Please complete a Location Form for each Practice Location.

Group Name:							
Practice Location Name:				Group Tax ID Number:			
Primary Office Address:	Street No	Direction	Street Name			Suffix	Suite
Primary Office City:			State:	Zip:	County:		
Primary Office Phone Number:			Primary Office Fax Number:				
PCP: Yes No		Capacity:					
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	To	To	To	To	To	To	To
	Closed	Closed	Closed	Closed	Closed	Closed	Closed
	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs
Does the location have access to Language Line Services?						Yes	No
Does the location offer translation services for written materials?						Yes	No
Does the location offer non-English languages, either spoken by the provider, office personnel or offered onsite by skilled medical interpreters?						Yes	No
If above question is yes, please list which non-English languages are provided at this location:							

ADA Information

Does your office meet ADA Parking Recommendations, Including ALL of the following: -Adequate, marked accessible (handicap) parking (1 in 25 or 10% of total spaces) that serve people with mobility disabilities. -At least 1 space that is van accessible available in your parking lot. -An access aisle next to each marked space.				Yes	No
Does your office meet Restroom Recommendations, Including ALL of the following: -Restroom large enough to accommodate a patient who uses an adult wheelchair or scooter. -The entry doors to the restrooms are at least 36" wide, and easy to open. -The toilet door or stall have a minimum clear opening of 32". -The top of the toilet seat 17-19" from the floor. -Grab bars behind and to the wall side of the toilet. -At least one open space (at least 42") to the side of the toilet. -The soap and towel dispensers 48" or less from the floor.				Yes	No
Does your office meet Exam Room Recommendations, Including ALL of the following: -At least one exam room available via an accessible route (no less than 36" wide) with an entry door at 32" clear opening with a minimum of 30" by 48" clear approach next to an examination table for transfer from a wheelchair. -Staff members trained to assist with transfers on/off of examination table.				Yes	No
Does your office meet Equipment Recommendations, Including ALL of the following: -Access to a wheelchair scale. -Access to a height adjustable exam table.				Yes	No
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
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. -An entry door at least 34" wide with a push pad or easy assist system. -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.				Yes	No
Is the provider's location on an accessible public transportation route?				Bus	Yes No
				Train	Yes No

Provider Location Form

Location 2

Please complete a Location Form for each Practice Location.

Group Name:							
Practice Location Name:				Group Tax ID Number:			
Primary Office Address:	Street No	Direction	Street Name				Suffix Suite
Primary Office City:			State:	Zip:	County:		
Primary Office Phone Number:			Primary Office Fax Number:				
PCP: Yes No		Capacity:					
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	To	To	To	To	To	To	To
	Closed	Closed	Closed	Closed	Closed	Closed	Closed
	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs
Does the location have access to Language Line Services?						Yes	No
Does the location offer translation services for written materials?						Yes	No
Does the location offer non-English languages, either spoken by the provider, office personnel or offered onsite by skilled medical interpreters?						Yes	No
If above question is yes, please list which non-English languages are provided at this location:							

ADA Information

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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
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Is the provider's location on an accessible public transportation route?				Bus	Yes No
				Train	Yes No

Provider Location Form

Location 3

Please complete a Location Form for each Practice Location.

Group Name:							
Practice Location Name:				Group Tax ID Number:			
Primary Office Address:	Street No	Direction	Street Name			Suffix	Suite
Primary Office City:			State:	Zip:	County:		
Primary Office Phone Number:			Primary Office Fax Number:				
PCP: Yes No		Capacity:					
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	To	To	To	To	To	To	To
	Closed	Closed	Closed	Closed	Closed	Closed	Closed
	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs
Does the location have access to Language Line Services?						Yes	No
Does the location offer translation services for written materials?						Yes	No
Does the location offer non-English languages, either spoken by the provider, office personnel or offered onsite by skilled medical interpreters?						Yes	No
If above question is yes, please list which non-English languages are provided at this location:							

ADA Information

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Does your office meet Exam Room Recommendations, Including ALL of the following: -At least one exam room available via an accessible route (no less than 36" wide) with an entry door at 32" clear opening with a minimum of 30" by 48" clear approach next to an examination table for transfer from a wheelchair. -Staff members trained to assist with transfers on/off of examination table.				Yes	No
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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
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. -An entry door at least 34" wide with a push pad or easy assist system. -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.				Yes	No
Is the provider's location on an accessible public transportation route?				Bus	Yes No
				Train	Yes No

Provider Location Form

Location 4

Please complete a Location Form for each Practice Location.

Group Name:							
Practice Location Name:				Group Tax ID Number:			
Primary Office Address:	Street No	Direction	Street Name			Suffix	Suite
Primary Office City:			State:	Zip:	County:		
Primary Office Phone Number:			Primary Office Fax Number:				
PCP: Yes No		Capacity:					
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	To	To	To	To	To	To	To
	Closed	Closed	Closed	Closed	Closed	Closed	Closed
	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs
Does the location have access to Language Line Services?						Yes	No
Does the location offer translation services for written materials?						Yes	No
Does the location offer non-English languages, either spoken by the provider, office personnel or offered onsite by skilled medical interpreters?						Yes	No
If above question is yes, please list which non-English languages are provided at this location:							

ADA Information

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Is the provider's location on an accessible public transportation route?				Bus	Yes No
				Train	Yes No

Provider Location Form

Location 5

Please complete a Location Form for each Practice Location.

Group Name:							
Practice Location Name:				Group Tax ID Number:			
Primary Office Address:	Street No	Direction	Street Name			Suffix	Suite
Primary Office City:			State:	Zip:	County:		
Primary Office Phone Number:			Primary Office Fax Number:				
PCP: Yes No		Capacity:					
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	To	To	To	To	To	To	To
	Closed	Closed	Closed	Closed	Closed	Closed	Closed
	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs	Open 24 Hrs
Does the location have access to Language Line Services?						Yes	No
Does the location offer translation services for written materials?						Yes	No
Does the location offer non-English languages, either spoken by the provider, office personnel or offered onsite by skilled medical interpreters?						Yes	No
If above question is yes, please list which non-English languages are provided at this location:							

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Is the provider's location on an accessible public transportation route?				Bus	Yes No
				Train	Yes No

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/Populations 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 Ill
Gay/Lesbian	School Based
Geriatric	Telemedicine
Hospital Based	Women
Home Based	Young Children
Treatment Modalities/ 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

Cognitive Therapy	Pain Management
Community Support Program	Rational 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	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
Disorders/Issues	
Addictive Medicine	Impulse disorders
ADD/ADHD	Infertility
Addictive Disorders	Inpatient Attending
Adjustment Disorder	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

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	