BAPTIST HEALTH PLAN
651 Perimeter Drive, Suite 300
Lexington, Kentucky 40517
Phone: 859.269.4475 or 800.787.2680

Please complete and fax form to:
Fax for KY: 859.335.3736 Fax for TN: 859.268.3576

Provider Rep Name

Date

Provider Data Form

(For CAQH credentialing purposes)

Satisfactory completion of Residency is required prior to Credentialing

Today's Date: _____

Are you registered with CAQH? ☐ Yes ☐ No If Yes, CAQH Provider ID #_____

Last Name First Name Middle Initial Gender ☐M ☐F

Date of Birth Medicare # Individual NPI #

Provider Type *(MD, DO, DPM etc)* DEA# License # Group NPI #

Specialty Are You Board Certified? ☐ Yes ☐ No If Yes, Board Name

Principal Admitting Hospital Name Medicare #

Other Hospital Privileges

Covering Physician/Hospitalist Group

Practice Name Tax ID# Primary Taxonomy Code

Primary Office Street Address Suite #

Primary Office City State County Zip

Primary Office Phone # Primary Office Fax #

Credential Contact Name Phone # Fax #

Credential Contact E-mail Address Languages Spoken (other than English)

Remittance Address (where you would like your payment mailed):

Remittance Company Name Tax ID#

Remittance Street Address Suite #

Remittance City State County Zip