

# Bluegrass Family Health

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: (615)872-1077

## 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

\_\_\_\_\_  
Date of Birth Social Security # NPI # State of Licensure & License #

\_\_\_\_\_  
Provider Type (MD, DO, DC, DDS, DMD, DPM, ARNP, PA-C, etc)

\_\_\_\_\_  
Specialty Applying As:  
 PCP  Specialist  Allied Health Professional  
 Locum Tenens  Hospitalist/Hospital Based

\_\_\_\_\_  
Are You Board Certified?  Yes  No If Yes, Board Name

\_\_\_\_\_  
Group Name Tax ID#

\_\_\_\_\_  
Primary Office Street Address Suite #

\_\_\_\_\_  
Primary Office City State County Zip

\_\_\_\_\_  
Primary Phone # Primary Fax # Credential Contact Name and E-mail Address

**Please Attach CV & W9**

**For Internal Use Only:**

CAQH# Assigned/Date: \_\_\_\_\_ CAQH file acceptable?  Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provider Services Rep: \_\_\_\_\_