

# CAQH Access Form

To ensure that HealthSmart can access your CAQH application, please complete this form and return to the appropriate email address based on your practice location indicated below.

**Contracted Group Name:** \_\_\_\_\_

**State Practice Location:** \_\_\_\_\_

**Provider Last Name:** \_\_\_\_\_ **Provider First Name:** \_\_\_\_\_

**Degree:** \_\_\_\_\_ **Specialty (as it relates to the practice):** \_\_\_\_\_

**CAQH Number:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Individual NPI:** \_\_\_\_\_ **Practice TIN:** \_\_\_\_\_

**If provider is a mid-level provider (NP, PA, CRNA, CNS), please provide the name of his/her supervising physician as required by state.**

**Attestation and the following are current:**

+ License #

+ NPI #

+ SSN #

+ Tax ID #

+ Explanation of gaps in work history

Yes  No

+ Explanation of gaps in education

+ Certificate of Insurance (COI)

+ Copy of Board certification

+ References

+ Curriculum vitae (CV)

+ W9

**Access granted to HealthSmart to access CAQH application**

Yes  No

**Do you practice exclusively within the inpatient setting? (e.g. Pathology, ER, Anesthesiology, Radiology, Nurse Practitioner, Physician Assistant, etc**

Yes  No

**Completed by (print):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**For additional information on CAQH, please see below.**

**CAQH Website:** <https://upd.caqh.org/oas/>

**CAQH Provider Help Desk**

Phone Number: 888.599.1771

Email address: [caqh.updhelp@acsgs.com](mailto:caqh.updhelp@acsgs.com)

**CAQH Provider Help Desk Hours**

7am-9pm EST – Monday – Thursday

7am-7pm EST – Friday