Provider Profile Sheet

SUBMISSION INSTRUCTIONS:
Submit completed form **with current W9** to:

- **Absolute Total Care:** *SouthCarolinaPDM@centene.com*
- **WellCare:** Your assigned Provider Engagement Account Manager **or** *ATCNetworkRelations@centene.com*

Group/Practice Name: **Tax ID:**

Full Name	NPI #	CAQH #	Medicaid ID or Medicare ID	Specialty	Age Limit	PCP (Y/N)	If PCP, Panel Open / Closed	Effective Date	Locations: A, B, C, D[2]

[1]Participating as Primary Care Physician (Yes or No)

[2]Indicate the letter of each location listed in the section below at which each provider renders services. Please indicate each Provider's primary office address by listing the letter for that location first (e.g., A, B, C, D or A only)

Practice/Facility Locations (include suite and building numbers)	Organizational NPI	Office Hours	Phone Number	Fax Number
A				
B				
C				
D				

If you have more practitioners than the space above allows, you may submit multiple sheets by photocopying this template or submit a roster that contains all of the above information.

Financial/Pay to Address:

Contract Representative:

Contract Representative Email Address:

Contract Representative Phone Number: