

Magellan Healthcare

Prospective Provider Information Profile

This form will be used for **informational purposes only**. It is not an application and completing and returning this form does not imply membership in the Magellan network. Please note, if there are multiple practitioners in the clinic, a separate Information Profile must be completed by each one.

Practitioner's Name: _____ Gender: ___ CAQH Id: _____

Clinic Name: _____ Email: _____

Address: _____ Phone: _____

City/St/Zip: _____ Fax: _____

Years in practice at this location: _____ Total years in practice: _____

Other practitioners at this location? ___Yes ___No How many? _____

Names and types of other practitioners (note: a separate Information Profile must be completed by each) _____

Acupuncture Education/School: _____

Year Completed: _____

Foreign language(s) _____

Magellan requires professional malpractice liability insurance coverage by providers with limits of liability at \$1 million per occurrence and \$3 million in the aggregate. Do you carry at least these levels or would you be willing to increase your coverage as required? ___Yes ___No

For L.Ac.'s:

Are you NCCAOM certified? ___Yes ___No

For M.D.'s:

What is your American Board of Medical Specialties (ABMS) specialty? _____

Are you Board Certified or Eligible? ___Yes ___No

Signature of Practitioner

Date

Please return to:

Magellan Healthcare

7805 Hudson Rd, Ste 190, Woodbury, MN 55125 or Fax (888) 656-1913