FOR MAGELLAN USE ONLY	
Individual MIS#	
Group MIS#	
Organization MIS#	

LA CSoC Interested Provider Form (IPF)

THIS IS NOT AN APPLICATION

Please do not accept any referrals or treat any members until you have been fully credentialed and contracted with Magellan.

Thank you for your interest in joining the Magellan network. In order for us to process your request, the following information is needed: Please fill out this Interested Provider Form and submit it along with your **LDH License**, completed **W9** and **Curriculum Vitae** (CV). Email ALL documents to LACSoCproviderquestions@magellanhealth.com or fax ALL documents to 1-888-656-4229.

Providers interested in joining the Magellan network must have an applicable taxonomy code. Please refer to the CSoC Allowable Taxonomy Code table when selecting your taxonomy code. To add or obtain your taxonomy code, go to **https://nppes.cms.hhs.gov/NPPES/Welcome.do?.**

Interested Providers are directed to the Medicaid Behavioral Health Services Provider Manual to review information about provider qualifications, requirements, and the types of licenses necessary to provide services.

If you are not already licensed, you may apply for an LDH license through the LDH, Health Standards Section (HSS) via license programs available on the HSSwebsite. For information about obtaining a DCFS license, please review information available on the DCFSLicensingwebsite. Once you receive your license, submit it, along with this completed form, W9, and CV to LACSoCProviderQuestions@magellanhealth.com.
Your **CV should consist of the following elements in Month/Year format**: Work history (reflecting month, year and job) and education including field of study for degree, internship (if applicable) and residency (if applicable).

If you are a group practice, each clinician wanting to join the network will need to fill out this form. Once your information has been received and processed you will be notified by mail within **60** days as to whether or not your request for inclusion in Magellan networks has been approved. Thank you again for your interest in Magellan Health in Louisiana.

Provider Type:	☐ **Individual**	☐ **Group Member**	☐ **Group**	☐ **Organization**

Section I (*Individuals and Group Members)*

IMPORTANT NOTE:

- ☐ **Individuals file claims with social security number only**
- ☐ **If you plan to bill with a tax ID number, you are not considered an Individual but rather a group.**
- ☐ **Please complete Sections II and III as applicable**

Last Name:	**First Name:**		**Middle:**	
Date of Birth:	**Gender:** ☐ **Male** ☐ **Female**	**License Type:**	**License #**	**Degree:**
SSN:	**Medicaid ID:**	**Email:**		
NPI# (Type 1–Required):	**Taxonomy Code (for Medicaid):**		**#CAQH Provider ID#:**	
Mailing Address:			**Attention:**	
City:	**State:**	**Zip Code:**	**Parish/County:**	
Phone:	**Fax:**	**Email:**		
Contact Name:	**Contact Title**		**Contact Email:**	
Primary Practice Address:			**Contact Phone:**	
City:	**State:**	**Zip Code:**	**Parish/County:**	
If a Group Member, Provide Group Name:				
Have you ever been employed by Magellan Health and/or one of its subsidiaries?	☐ **Yes**	☐ **No**		

Section II (*Groups and Organizations only)*				
Group/Organization Name:				
Legal Name (if different):			NPI: (Type 2 – Required):	
Is your Group/Organization currently contracted with Magellan?	☐ Yes	☐ No	Medicare #:	
Mailing Address:			Attention:	
City:	State:	Zip Code:	Parish/County:	
Phone:	Fax:	Email:		
Contact Name:	Contact Phone:	Contact Email:		
Primary Practice Address:				
City:	State:	Zip Code:	Parish/County:	

Section III – Practice Information (*All)*					
General Categories:	☐ Mental Health	☐ Substance Abuse			
Age Categories:	☐ Younger Child (0-5)	☐ Older Child (6-12)	☐ Adolescent (13-21)		
Language Spoken:	☐ English	☐ Spanish	☐ French	☐ Sign Language	☐ Other:
Specialties:	1.	2.	3.		
Voluntary Information:					
Ethnic background:	☐ Black/African American	☐ Hispanic/Latino	☐ Asian/Pacific Islander		
	☐ Native American/Alaska	☐ Caucasian	☐ Other		

***If you wish for Magellan to use your CAQH application, you must have selected ALL to give permission for Magellan to access your information. If you did not select ALL, you will need to give permission for Magellan to have access to your application.**

Required Information on Ownership Status:

- Please identify your four digit ownership code: _____

Below is a list of all applicable ownership codes. For example, if you are proprietary individual, your code is: 6M04

OWNERSHIP CODES		
NMTCOD	NMTD10	NMPTD30
6K	01	VOLUNTARY NONPROFT REL ORG
6L	02	VOLUNTARY NONPROFT OTHER
6M	04	PROPRIETARY INDIVIDUAL
6N	05	PROPRIETARY CORPORATION
6O	06	PROPRIETARY PARTNERSHIP
6P	07	PROPRIETARY OTHER
6Q	08	PROPRIETARY MULTIPLE OWNERS
6R	09	GOVERNMENT FEDERAL
6S	10	GOVERNMENT STATE
6T	11	GOVERNMENT CITY
6U	12	GOVERNMENT COUNTY
6V	13	GOVERNMENT CITY COUNTY
6W	14	GOVERNMENT HOSP DISTRICT

NOTE: All providers MUST identify an ownership code. Failure to do so will result in the Interested Provider Form being returned without being processed.