



Provider Self-Registration Request Instructions

To be eligible for self-registration in the CAQH Universal Provider Datasource®, you must be one of the following licensed practitioner types:

Medical Doctor	Doctor of Podiatric Medicine
Doctor of Dental Surgery	Doctor of Chiropractics
Doctor of Dental Medicine	Doctor of Osteopathy

Allied Practitioners

Acupuncturist	Nurse Midwife
Audiologist	Nurse Practitioner
Biofeedback Technician	Nutritionist
Alcohol/Drug Counselor	Occupational Therapist
Christian Science Practitioner	Optometrist
Clinical Nurse Specialist	Optician
Clinical Psychologist	Pharmacist
Clinical Social Worker	Physician Assistant
Professional Counselor	Physical Therapist
Licensed Practical Nurse	Dietician
Massage Therapist	Registered Nurse
Marriage/Family Therapist	Certified Registered Nurse Anesthetist
Naturopath	Registered Nurse First Assistant
Neuropsychologist	Respiratory Therapist
Midwife	Speech Pathologist

If you are under contract with one of CAQH's participating organization, you are not eligible for self-registration. You may check the list of participating organizations by visiting the following web site: http://www.caqh.org/ucd_health_participating.php If you are currently contracted or in the process of contracting with one of the participating organizations, please contact that organization regarding your use of the CAQH Universal Provider DataSource.

To request self-registration, please complete the attached form and either email to info@caqh.org or fax to 1-202-861-1454. You must fill in all fields with an asterisk (*). You will receive a welcome kit from CAQH within 5 to 10 business days from receipt of your request. If there is a problem with your request, we will contact you at the phone number you supply at the bottom of the form.

Thank you for your interest in CAQH's Universal Provider DataSource!



Provider Self-Registration Request

After you have entered all the information requested, please email to Info@caqh.org or fax to 1-202-861-1454

Name (Last, first and middle initial)*:	
Suffix:	
Provider Type (MD, DO, PA, RN, etc.):*	
DOB*:	
UPIN # (if applicable):	
License Number and State of Issue*:	
Primary Office Address*:	
Primary Office City*:	
Primary Office State*:	
Primary Office Zip*:	
Primary Office Phone*:	
Primary Office Fax:	
Email Address:	
Credentialing Contact Name, Phone and Email Address(if not self):	
Phone number to contact you if there are any questions with your request*:	

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