Magellan Healthcare
Occupational Therapy
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: ____ e-mail: __________________

Address: ____ Phone: __________________

City/St/Zip: ______________________________________ Fax: ____________________

Tax ID: __________________________

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) ____

____

Occupational Therapy Education/School: ____

Year Completed: ____________________________

Please list the license number(s) and state(s) where you have active licensure:

License number: ______________________ State: __________________

License number: ______________________ State: __________________

License number: ______________________ State: __________________

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

___________________________________ ______________

Signature of Practitioner Date

Please return to:
Magellan Healthcare
PO Box 211532, Eagan, MN 55121 or Fax (888) 656-1913