Georgia Department of Public Health

BABIES CAN'T WAIT

www.BCW-BIBS.com

DISTRICT EMPLOYEE ENROLLMENT FORM

Complete this form if you are a Provider employed by a District.

District Information

Select the District in which you provide services and **indicate only one District per form**. If services are provided for multiple Districts, an individual enrollment packet will be required for each District.

- ❑ 1-1 Rome (Northwest Health District)
- ❑ 1-2 Dalton (North Georgia Health District)
- ❑ 2 Gainesville (North Health District)
- ❑ 3-1 Cobb/Douglas (Cobb/Douglas Health District)
- ❑ 3-2 Fulton (Fulton Health District)
- ❑ 3-3 Clayton (Clayton County Health District)
- ❑ 3-4 East Metro (East Metro Health District)
- ❑ 3-5 DeKalb (DeKalb Health District)
- ❑ 4 LaGrange (LaGrange Health District)
- ❑ 5-1 Dublin (South Central Health District)
- ❑ 5-2 Macon (North Central Health District)
- ❑ 6 Augusta (East Central Health District)
- ❑ 7 Columbus (West Central Health District)
- ❑ 8-1 Valdosta (South Health District)
- ❑ 8-2 Albany (Southwest Health District)
- ❑ 9-1 Coastal (Coastal Health District)
- ❑ 9-2 Waycross (Southeast Health District)
- ❑ 10 Athens (Northeast Health District)

Provider Information

❑ **Add New Provider**

❑ **Change Provider Information**
Please indicate the type of change: ❑ Name ❑ Address ❑ Phone ❑ Fax ❑ NPI ❑ Email

Provider First Name_____ MI_____ Last Name_____

Address_____

City_____ State_____ Zip_____

Phone # (____) _____ EXT_____ Fax (____) _____

Provider NPI # _____ Email_____

In-Network Private Insurance Information

Provide information for any of the private insurance carriers listed where you are an In-Network Provider. If an In-Network Provider ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider Enrollment will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Private Insurance information, leave the following table blank.

Georgia Department of Public Health BABIES CAN'T WAIT

www.BCW-BIBS.com

DISTRICT EMPLOYEE ENROLLMENT FORM

Complete this form if you are a Provider employed by a District.

Carrier Name	In-Network Provider ID	Start Date	End Date
Aetna		/ /	/ /
Blue Cross Blue Shield (BCBS)		/ /	/ /
Cigna		/ /	/ /
Tri-Care		/ /	/ /
United Health Care (UHC)		/ /	/ /
		/ /	/ /
		/ /	/ /

Medicaid/CMO Information

Provide information for any of the Medicaid types where you are a Medicaid enrolled Provider. If a Medicaid ID is provided, but the Start Date is left blank, then the date this form is received by CFO Provider Enrollment will be used as the Start Date.

Please Note: When submitting updates, if no changes are required for Medicaid or CMO information, leave the following table blank.

Provide information for all which apply:		Care Management Organization (CMO)				Care Management Organization (CMO) PeachCare for Kids					
Medicaid ID	Traditional Medicaid	Amerigroup	Peach State	WellCare	Care Source	Amerigroup	Peach State	WellCare	Care Source	Start Date	End Date
	☐	☐	☐	☐	☐	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	☐	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	☐	☐	☐	☐	☐	/ /	/ /
	☐	☐	☐	☐	☐	☐	☐	☐	☐	/ /	/ /

District Signature _____ Date _____

District Contact Name (please print)_____ Phone # (_____)_____

Please complete this Enrollment Form and submit to the District

For questions please contact Provider Registration at 855-708-6612 option 2