

Credentialing Checklist

Provider Full Name _____ Date of Birth ___/___/___

Home Address _____ Place of Birth _____
City/State _____
SS # _____ - _____ - _____

Practice Address _____ Tel # () _____
Street Address, City, State, Zip Fax # () _____
Email Address: _____ @ _____ . _____ Cell # () _____

Billing/Mailing Address _____
P.O. Box/Street Address, City, State, Zip (if different than practice address)

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Documents Needed

- Professional License & DEA if applicable
- Malpractice Insurance Cover Sheet
- Copy of Diplomas
- Resume (with private practice info)
- Copy of CEU's (past 2 years)
- Professional References
- Covering Clinician Name and Number
- Certifications or Prof Memberships
- Referral Sources (list on next page)
- Date License was issued ___/___/___

Schedule (days and times available to see patients):

Monday _____ Tuesday _____ Wednesday _____
Thursday _____ Friday _____ Saturday _____ Sunday _____

Clients

Ages: _____

Appointment Types: Individual Family Couples Testing Other: _____

Specialties/Certifications:

Currently on any insurance panels (provide company name and provider #)?

Other frequently asked questions:

Languages spoken other than English?

W-9 status with tax identification number or social security number?

Is practice location handicap accessible?

Emergency coverage protocol (answering service, voice mail, pager, etc)?

Medical/Professional School with Year of Graduation?

Did you obtain a NPI Number? If yes, provider number: _____.

GROUP INFORMATION:

Tax Id Number:

Billing Address:

How Many Providers:

Specialties:

Age Groups:

CAQH Provider Number and/or User Name/Password:

NOTES: