

Credentialing Checklist

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

Home Address _____ Place of Birth _____
City/State

SS # - -

Tax ID -

Primary 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)

+++++

Documents Needed

- Professional License & DEA if applicable
- Malpractice Insurance Cover Sheet
- Copy of Diplomas
- Resume (with private practice info)
- Covering Clinician Name and Number
- Copy of Board Certification
- Copy of State Controlled Substance
- Date License was issued ___/___/___

Schedule (days and times available to see patients):

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

Clients

Ages: _____

Specialties/Certifications:

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

_____	_____
_____	_____
_____	_____

Claim Shack PO Box 212, Centerville, MA 02632 (508) 280.7218

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: _____.

CAQH Provider Number and/or User Name/Password:

NOTES: