

PROVIDER CREDENTIALING CHECKLIST

To begin the application process, please complete the following: [UPPSes print layout](#)

Provider Last Name:		Provider First Name:		NPI #
Credentialing Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No		Credentialing Email:	Credentialing Phone:	
Joining a group practice? <input type="checkbox"/> Yes <input type="checkbox"/> No		Group Name:	Tax ID:	
CAGE ID #	State License #		Are you enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Example: SPC PPO HEP SM <small>*SP Counties: Albany, Berks, Broward, Columbia, Delaware, Des Moines, Fulton, Greene, Hardey, Montgomery, Orange, Osage, Putnam, Sevier, Utah, Washington, Wayne, Westchester, Wilkes, Worthington, Schuette, Colquhoun, Raleigh, Rockwell, Somerset, Eschwege, Suffolk, Sullivan, Nassau.</small>				
Physician Type: (select one) <input type="checkbox"/> PCP <input type="checkbox"/> SPECIALIST <input type="checkbox"/> DUAL (PCP and SPECIALIST) Dual provides initial visit and PCP appointment guidelines.				
REQUESTED SPECIALTY as appear in EndHealthDirectory				

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To ensure accurate data entry in our studies, directors, please confirm the following items on each service location from your CACH application:

... ..

- ☐ All on CACM under TSM above (complete section 1 only) ☐ Limited to the following below: (complete section 1 and 2)
If more than 6 locations: (complete section 1 and select two of all service locations on (attached))

SECTION 3: PHYSICIAN LOCATION	
1. Address:	Service Address: <input type="checkbox"/> Yes <input type="checkbox"/> No Can patients make appointments with you at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No Should location refer in the directory? <input type="checkbox"/> Yes <input type="checkbox"/> No
Appointment Place #:	Are there any age restrictions to your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No
Age: <input type="checkbox"/> 0-24yrs <input type="checkbox"/> 25yrs and over 25 <input type="checkbox"/> Indicate minimum age _____ Indicate maximum age _____	
<input type="checkbox"/> (H. Office) <input type="checkbox"/> Hospital-based <input type="checkbox"/> Outpatient-based <input type="checkbox"/> Outpatient, surgical center	

SECTION 2: ADDITIONAL OFFICES	
3. Address:	Service Address: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Can patients make appointments with you at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Should services prior to this opening? <input type="checkbox"/> Yes <input type="checkbox"/> No
Appointment Place(s):	Are there any age restrictions to your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is different TOL, W. Saturday? <input type="checkbox"/> Yes <input type="checkbox"/> No	TOL
Ages: <input type="checkbox"/> 0-20 yrs <input type="checkbox"/> 20 yrs and over OR <input type="checkbox"/> Indicate minimum age _____ Indicate maximum age _____ <input type="checkbox"/> (In-Office) <input type="checkbox"/> Resident Hospital <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Perio/dentary surgical center?	

3. Address:	Service Address: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Can patients make appointments with you at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Should location print in the directory? <input type="checkbox"/> Yes <input type="checkbox"/> No
Appointment Phone #	Are there any age restrictions in your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is different TBE, W-Statistical? <input type="checkbox"/> Yes <input type="checkbox"/> No	TBE:
Age: <input type="checkbox"/> 0-20yrs <input type="checkbox"/> 21yrs and over <input type="checkbox"/> 20-30 <input type="checkbox"/> 31-40 <input type="checkbox"/> 41-50 <input type="checkbox"/> 51-60 <input type="checkbox"/> 61-70 <input type="checkbox"/> 71-80 <input type="checkbox"/> 81-90 <input type="checkbox"/> 91-100 <input type="checkbox"/> Indicate minimum age _____ indicate maximum age _____	
<input type="checkbox"/> (a. office) <input type="checkbox"/> (b. hospital) <input type="checkbox"/> (c. outpatient hospital) <input type="checkbox"/> (d. ambulatory surgical center)	
<input type="checkbox"/> (a. office) <input type="checkbox"/> (b. hospital) <input type="checkbox"/> (c. outpatient hospital) <input type="checkbox"/> (d. ambulatory surgical center)	

Example Of Physician Credentialing Manual

Anne Roberts



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Enjoying the Beat of Phrase: An Emotional Symphony within **Example Of Physician Credentialing Manual**

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