

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: SHS PPO HEP SM <small>*HSA Counties: Albany, Bronx, Broward, Columbia, Delaware, Des Moines, Fulton, Greene, Hardey, Montgomery, Orange, Osage, Putnam, Sevier, Utah, Washington, Warren, Westchester, Winchester, York *Medicaid States: Alaska, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, Wisconsin, Wyoming</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 EndUserHealthDirectory				

REPRODUCED FROM THE JOURNAL OF THE

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

... ..

- ☐ All on CACFP under TIF (please 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 letterhead)

SECTION 3: PRIMARY 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 get in the directory? <input type="checkbox"/> Yes <input type="checkbox"/> No
Appointment Phone #:	Are there any age restrictions to your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No
Ages: <input type="checkbox"/> 0-20yrs <input type="checkbox"/> 21yrs and over <input type="checkbox"/> Indicate minimum age _____ Indicate maximum age _____	
<input type="checkbox"/> (in-office) <input type="checkbox"/> Hospital Inpatient <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Ambulatory 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 the opening? <input type="checkbox"/> Yes <input type="checkbox"/> No
Appointment Please 4:	Are there any age restrictions to your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Different TDM, W. Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	TDM
Ages: <input type="checkbox"/> 0 - 20yrs <input type="checkbox"/> 20yrs 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"/> Perinatal/Infant/Neonatal	

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-2 attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	TBE:
Ages: <input type="checkbox"/> 0-20yrs <input type="checkbox"/> 20yrs and over <input type="checkbox"/> 20yrs and over <input type="checkbox"/> Indicate minimum age _____ Indicate maximum age _____	
<input type="checkbox"/> (Is Office) <input type="checkbox"/> Emergency Hospital <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Outpatient surgical center	
<input type="checkbox"/> (Is Office) <input type="checkbox"/> Emergency Hospital <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Outpatient surgical center	

Example Of Physician Credentialing Manual

D Keegan



Example Of Physician Credentialing Manual:

The book delves into Example Of Physician Credentialing Manual. Example Of Physician Credentialing Manual is a crucial topic that needs to be grasped by everyone, ranging from students and scholars to the general public. This book will furnish comprehensive and in-depth insights into Example Of Physician Credentialing Manual, encompassing both the fundamentals and more intricate discussions.

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 - Chapter 3: Example Of Physician Credentialing Manual in Everyday Life
 - Chapter 4: Example Of Physician Credentialing Manual in Specific Contexts
 - Chapter 5: Conclusion
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