

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 <input type="checkbox"/> HMO <input type="checkbox"/> HMO+ <small>*HMO+ Counties: Albany, Bronx, Broward, Columbia, Delaware, Delaware, Fulton, Greene, Hardey, Montgomery, Orange, Orange, Putnam, Sevier, Union, Washington, Wilkes, Washington, Schuylker, Columbia, Buchanan, Raleigh, Southern, Somerset, Surrogate, Suffolk, Sullivan, Warren</small> | | | | | |
| Physician Type: (select one) <input type="checkbox"/> PCP <input type="checkbox"/> SPECIALIST <input type="checkbox"/> DUAL (PCP and SPECIALIST) Dual provides initial and most PCP appointment guidelines. | | | | | |
| REQUESTED SPECIALTY as appear in Healthcare/Health Directory | | | | | |

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To ensure accurate data entry in our studies, directors, please confirm the following facts on each service location from your CACN 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 five of all service locations on letterhead)

| 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 Plans II: | 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"/> (Hr. Office) <input type="checkbox"/> Hospital-based <input type="checkbox"/> Outpatient-based <input type="checkbox"/> Distribution: surgical assistant | |

| SECTION 2: ADDITIONAL OFFICES | |
|--|---|
| 2. 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 screening? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appointment Place B: | Are there any age restrictions to your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is different TBM, W. Saturday? <input type="checkbox"/> Yes <input type="checkbox"/> No | TBM |
| 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"/> Perinatal/childbirth center? | |

| | |
|---|---|
| 5. 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, IV-Subcut? <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+ (Indicate minimum age _____ Indicate maximum age _____) | |
| <input type="checkbox"/> (In-office) <input type="checkbox"/> Hospital-based <input type="checkbox"/> Outpatient hospital <input type="checkbox"/> Outpatient surgical center | |
| <input type="checkbox"/> (In-office) <input type="checkbox"/> Hospital-based <input type="checkbox"/> Outpatient hospital <input type="checkbox"/> Outpatient surgical center | |

Example Of Physician Credentialing Manual

Arturo Cuomo



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