New Facility Credentialing Info Sheet & Checklist

1. Main contact info:
    a. Name: _____
    b. Cell phone: _____
    c. Email: _____
2. Location # 1 Info:
    a. Location name: _____
    b. Address: _____
    c. Mailing and Pay to Address: ☐ Check here if same as above

    _____
    d. Phone Number: _____
    e. Fax Number: _____
    f. Office manager: _____
    g. Email: _____
    h. Office Hours: _____
    i. List of services for this location:

    _____

    _____

    _____
    j. Group NPI #: _____
    k. Incorporation Date: _____
    l. Medicaid Number (if applicable): _____
    m. List of all providers at this location:

    _____

    _____

    _____

    _____

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Phone: 855-854-6332 Fax: 727-683-9536 Email: Carol@integrativepracticesolutions.com

n. Medical Malpractice for Location:
    i. Policy Number: _____
    ii. Current effective date: _____
    iii. Current expiration date: _____
    iv. Carrier name: _____
    v. Carrier address: _____
    vi. Amount of coverage per-occurrence: _____
    vii. Amount of coverage aggregate: _____
o. Other insurance carries this location is in network with:
    i. Insurance Carrier Name: _____
    ii. Username: _____
    iii. Password_____
p. Other insurance carries this location is in network with:
    i. Insurance Carrier Name: _____
    ii. Username: _____
    iii. Password_____

3. Location # 2 Info:
    a. Location name: _____
    b. Address: _____
    c. Mailing and Pay to Address: ☐ Check here if same as above

    _____
    d. Phone Number: _____
    e. Fax Number: _____
    f. Office manager: _____
    g. Email: _____
    h. Office Hours: _____
    i. List of services for this location:

    _____

    _____

    _____
    j. Group NPI #: _____

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k. Incorporation Date: _____

l. Medicaid Number (if applicable): _____

m. List of all providers at this location:

_____

_____

_____

_____

n. Medical Malpractice for Location:

i. Policy Number: _____

ii. Current effective date: _____

iii. Current expiration date: _____

iv. Carrier name: _____

v. Carrier address: _____

vi. Amount of coverage per-occurrence: _____

vii. Amount of coverage aggregate: _____

o. Other insurance carries this location is in network with:

i. Insurance Carrier Name: _____

ii. Username: _____

iii. Password_____

p. Other insurance carries this location is in network with:

i. Insurance Carrier Name: _____

ii. Username: _____

iii. Password_____

4. Provider #1 Info:

a. Name: _____

b. Address: _____

c. SSN: _____

d. DOB: _____

e. Birth City and State: _____

f. Medical School Info:

i. Start Date: _____

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ii. Graduation Date: _____

iii. Certificate Received: _____

g. Board of Certification:

i. Name of the certifying board: _____

ii. Initial certificate date: _____

iii. Expiration date: _____

h. NPPES (for creating and retrieving NPI numbers:

i. Username: _____

ii. Password: _____

i. PECOS (for applying and maintaining Medicare):

i. Username: _____

ii. Password: _____

j. CAQH (for applying and maintaining commercial insurance):

i. Username: _____

ii. Password: _____

k. DEA Number: _____

l. DEA Expiration Date: _____

m. Medicare PTAN #: _____

n. Medical Malpractice for Provider:

i. Policy Number: _____

ii. Current effective date: _____

iii. Current expiration date: _____

iv. Carrier name: _____

v. Carrier address: _____

vi. Amount of coverage per-occurrence: _____

vii. Amount of coverage aggregate: _____

5. Provider #2 Info:

a. Name: _____

b. Address: _____

c. SSN: _____

d. DOB: _____

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e. Birth City and State: _____

f. Medical School Info:

   i. Start Date: _____

   ii. Graduation Date: _____

   iii. Certificate Received: _____

g. Board of Certification:

   i. Name of the certifying board: _____

   ii. Initial certificate date: _____

   iii. Expiration date: _____

h. NPPES (for creating and retrieving NPI numbers:

   i. Username: _____

   ii. Password: _____

i. PECOS (for applying and maintaining Medicare):

   i. Username: _____

   ii. Password: _____

j. CAQH (for applying and maintaining commercial insurance):

   i. Username: _____

   ii. Password: _____

k. DEA Number: _____

l. DEA Expiration Date: _____

m. Medicare PTAN #: _____

n. Medical Malpractice for Provider:

   i. Policy Number: _____

   ii. Current effective date: _____

   iii. Current expiration date: _____

   iv. Carrier name: _____

   v. Carrier address: _____

   vi. Amount of coverage per-occurrence: _____

   vii. Amount of coverage aggregate: _____

Location Documentation Checklist

Please gather and submit these documents for ***each location*** being credentialed

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☐ Property Liability Insurance

☐ Any State or County Licenses, including business license (if required)

☐ Articles of Incorporation (copy of Secretary of State registration)

☐ Current dated W-9

☐ Copy of Voided Check or Bank letter with routing and account number. Name on account must match legal business name on FEIN letter from IRS

☐ Copy of IRS CP-575 letter or 147c letter from IRS confirming FEIN# (Tax ID)

☐ Copy of IRS Form 8832 (type of entity designation, i.e. LLC, etc.)

☐ Original letter from Medicare for each facility

☐ Copy of Medical Malpractice face sheet

Provider Documentation Checklist

Please gather and submit these documents for ***each provider*** being credentialed

☐ Copy of hospital admitting privileges document

☐ Copy of medical license

☐ Copies of all accreditations or certifications

☐ Copy of Medical Malpractice face sheet

Please return the info sheet and all related documents to either Carol@integrativepracticesolutions.com or fax to 727-683-9536.

***Note: There may be items outside of this checklist that local insurance companies require. Please work closely with IPS staff to return all necessary information and documentation.**

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