CREDENTIALING QUESTIONS & DOCUMENTS NEEDED

NAME & LAST NAME ____________________

DOB __________ **SS#** __________ **ME LICENSE #** __________

DEA # __________ **INDIVIDUAL NPI#** __________

CELL PHONE# __________ **CAQH#** __________ **BCBS #** __________

SPECIALTY # 1 __________ **SPEACIALTY # 2** __________

GROUP NAME ____________________

TAX ID# __________ **NPI#** __________

OFFICE ADDRESS #1 ____________________

PHONE# __________ **FAX#** __________

OFFICE ADDRESS #2 ____________________

PHONE# __________ **FAX#** __________

OFFICE HRS #1 __________ **OFFICE HRS #2** __________

SERVICES OFFERED / RENDERED:

____

____

____

____

TYPE OF 24R COVERAGE? ____________________

AREA OF COVERAGE ____________________

AGE LIMIT OF PATIENTS **from** __________ **thru** __________

NAME & ADDRESS OF MEDICAL SCHOOL

____

YEAR OF GRADUATION ____________________

INTERNSHIP ____________________

From __________ **Thru** __________

FELLOWSHIP ____________________

From __________ **Thru** __________

LIST 3 WORK REFERENCES: NAME, ADDRESS & PHONE #

1. ____________________
2. ____________________
3. ____________________

HOSPITAL PRIVILEDGES / NAME, ADDRESS & PHONE#

____

HOSPITAL PRIVILEDGES / NAME, ADDRESS & PHONE#

____

HOSPITAL PRIVILEDGES / NAME, ADDRESS & PHONE#

____

HOSPITAL PRIVILEDGES / NAME, ADDRESS & PHONE#

____

MALPRACTICE YES OR NO

IF YES, INSURANCE INFO: ____________________

____

CREDENTIALING DOCUMENTS NEEDED

1. **CV – CURRICULUM VITAE**
2. **MALPRACTICE HISTORY**
3. **MEDICAL LICENSE**
4. **DEA LICENSE**
5. **MALPRACTICE FACESHEET**
6. **PROFESSIONAL REFFERENCES (3)**
7. **HOSPITAL PRIVILEDGES ATTESTATION**
8. **BOARD CERTIFICATION DIPLOMA (IF APPLICABLE)**
9. **COPY OF MEDICAL DIPLOMAS**
10. **FOR GROUPS – COPY OF AHCA LICENSE**
11. **COPY OF DRIVERS LICENSE**