CLIENT CREDENTIALING CHECKLIST:

Use this checklist to ensure that you have provided DSS with everything necessary to expedite your credentialing process.

Personal Information

- ☐ Full Name: _____
- ☐ City of Birth: _____
- ☐ DOB: _____
- ☐ Home Address: _____
- ☐ Email: _____
- ☐ Fax Number: _____
- ☐ Copy of State License
  - License Number: _____
  - Issue Date: _____
  - Expiration Date: _____
- ☐ Copy of DEA License
  - Federal DEA Number: _____
  - Issue Date: _____
  - Expiration Date: _____
- ☐ Copy of Professional Liability Insurance
  - Provide history of any malpractice or liability claims
  - Documentation of settlements or judgements relating to malpractice or alleged malpractice
- ☐ Copy of W-9 Tax form, Signed and Complete.
- ☐ Copy of Current Board renewal certificate (if applicable)
- ☐ Do you Prescribe Drugs? (Please check the following)
  - Yes
  - No
- ☐ TIN Number _____
- ☐ NPI Number _____
- ☐ Are you a Participating Medicare Provider?
  - NO
  - Yes:
    - Medicare Number: _____UPIN: _____
- ☐ Are you a participating Medicaid Provider?
  - NO
  - Yes
    - Medicaid Number: _____ Medicaid State: _____
    - USMLE Number: _____
    - Workers Compensation Number: _____

EDUCATION:

- Undergraduate School: _____
  - Start Date: _____End Date: _____
  - Degree Awarded: _____
  - Did you complete your undergraduate education at this school? Y / N
- Graduate School: _____
  - Start Date: _____ End Date: _____
  - Degree Awarded: _____
  - Did you complete your graduate education at this school? Y / N

TRAINING:

- Please provide all training programs you attended.
  - Institution, Address, Telephone, Fax, etc.
  - Did You complete this training program at this institution? Y / N
    - If not, please provide explanation.
  - Internship/Residency/Fellowship? (circle all that apply)
    - If yes, provide Department/Specialty & Name of Director of each program.

Professional/ Medical Specialty Information:

- Board Certified? Y / N
  - Please provide copy of board certification certificate
  - Initial Certification Date: _____
  - Recertification Date (if applicable): _____
  - Expiration Date: _____
    - Do you wish to be listed in the directory under this specialty? HMO/PPO/POS?
- Other Certifications
  - Basic Life Support? Y / N
    - If yes, provide expiration date: _____
  - CPR? Y / N
    - If yes, provide expiration date: _____
  - ADV Cardiac Life Support? Y / N
    - If yes, provide expiration date: _____
  - Neonatal Advanced Life Support? Y / N
    - If yes, provide expiration date: _____
  - ADV Life Support in OB? Y / N
    - If yes, provide expiration date: _____
  - ADV Trauma Life Support? Y / N
    - If yes, provide expiration date: _____
  - Pediatric Advanced Life Support? Y / N
    - If yes, provide expiration date:_____

Office Manager Information:

- ☐ First & Last Name: _____
- ☐ Telephone: _____
- ☐ Fax: _____
- ☐ Email Address: _____

Billing Contact:

- ☐ Check box to use Office Manager & Office Address as billing information
    - If no, provide name and address of billing contact.

Open Practice Status:

- ☐ Are there any practice limitations? Y / N
    - Gender Limitations? Y / N
    - Age Limitations? Y / N
    - Other: _____

Languages:

- ☐ Please list any Non-English Languages spoken by the office personnel: _____
- ☐ Interpreters Available? Y / N

Accessibilities:

- ☐ Does this office meet ADA Accessibility Requirements? Y / N
- ☐ Handicapped Access for the following:
    - Building? Y / N
    - Parking? Y / N
    - Restroom? Y / N
- ☐ Does this site offer other services for the disabled?
    - Text Telephony (TTY) Y / N
    - American Sign Language Y / N
    - Mental / Physical Impairment Services Y / N
- ☐ Accessible by Public Transportation?
    - Bus Y / N
    - Subway Y / N
    - Regional Train Y / N
    - Other: _____

Partners/Associates:

- ☐ Please list all Partners/Associates at this Practice:

_____

_____

Covering Colleagues:

- Please list all *Covering* Colleagues that are NOT partners/associates at this practice:

Hospital Affiliations:

- Do you have hospital privileges? Y / N
  - If yes, please provide:
    - Primary Hospital: _____
    - Address: _____
    - Telephone: _____ Fax: _____
    - Department Name: _____
    - Department Director: _____
    - Affiliation Start Date: _____ Affiliation End Date: _____
    - Full, Unrestricted Privileges? Y / N
    - Are privileges temporary? Y / N
    - Admitting Privilege Status: (e.g: none, full, unrestricted, provisional, temporary)
      - _____
    - Of your total annual admissions, what percentage is to this hospital?_____%

Work History:

Please provide **all** work history: (Include additional pages if needed)

- Practice Name: _____
- Address: _____
- Telephone: _____
- Start Date: _____
- End Date: _____
- Reason for departure: _____

- Practice Name: _____
- Address: _____
- Telephone: _____
- Start Date: _____
- End Date: _____
- Reason for departure: _____

- Practice Name: _____
- Address: _____
- Telephone: _____
- Start Date: _____
- End Date: _____
- Reason for departure: _____

Gaps in Professional/ Work History:

Please explain any time periods or gaps in training or work history that were longer than 3 months:

- Gap Start Date: _____
- Gap End Date: _____

Professional References:

Please provide three professional references to whom you are not related to or are not partners with in your practice.

- Name: _____
- Address: _____
- Telephone: _____
- Fax: _____

- Name: _____
- Address: _____
- Telephone: _____
- Fax: _____

- Name: _____
- Address: _____
- Telephone: _____
- Fax: _____

Please List all Insurance Companies that you would like to be credentialed with below:

1.	**10.**
2.	**11.**
3.	**12.**
4.	**13.**
5.	**14.**
6.	**15.**
7.	**16.**
8.	**17.**
9.	**18.**