|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Provider Name: Date:** | | | | |
| **Required Professional Documents to Obtain** | **Date Sent (Or Given to Provider)** | **Missing Information** | **Responsible Person:** | **Status Update / Notes** |
| Accreditation Letter/ Certificate |  |  |  |  |
| CMS Certification / Letter |  |  |  |  |
| Controlled Substance License / Certificate |  |  |  |  |
| DEA License |  |  |  |  |
| Facility / Department Description (services being provided) |  |  |  |  |
| Federal Tax ID |  |  |  |  |
| General Liability Insurance $1,000,000 per incident, Annual Aggregate $1,000,000 |  |  |  |  |
| Medicaid Number |  |  |  |  |
| Medicare Number |  |  |  |  |
| National Provider Identification (NPI) |  |  |  |  |
| Professional Liability Insurance $1,000,000 per incident, Annual Aggregate $3,000,000 |  |  |  |  |
| State Medical License |  |  |  |  |
| W-9 |  |  |  |  |
|  |  |  |  |  |
| **Required Personal Documents to Obtain** |  |  |  |  |
| Application |  |  |  |  |
| Board Certification(s) |  |  |  |  |
| College Degree |  |  |  |  |
| CV (Curriculum Vitae) |  |  |  |  |
| Driver's License or Passport Photo |  |  |  |  |
| ECFMG Certificate (If Educated Outside of The United States) |  |  |  |  |
| Employee Health (Copy of Immunization Record) |  |  |  |  |
| Hospital Privileges Verification |  |  |  |  |
| Peer Recommendations and/or 3 Reference Letters |  |  |  |  |
|  |  |  |  |  |
| **Credentialing Point of Contact:** |  |  |  |  |
| Name: |  |  |  |  |
| Email: |  |  |  |  |
| Phone: |  |  |  |  |
|  |  |  |  |  |
| **Approved By: Approval Date:** |  |  |  |  |
| Name: |  |  |  |  |
| Title: |  |  |  |  |
| Email: |  |  |  |  |
| Phone |  |  |  |  |
| Signature: |  |  |  |  |
|  |  |  |  |  |