PROVIDER AND FACILITY CREDENTIAL CHECKLIST

Legal Business Name: _____

Practitioner Name: _____

Specialty: _____**County**: _____ **Solo Practice:** __YES __NO

Medical Provider Type: ____**PCP**____**SPEC** ____**ALLIED**____**ANCILLARY** ____**HOSPITAL**

Hospital Based Practitioner: _____**YES** _____**NO** (Hospital based is defined as those practitioners who practice exclusively within the inpatient setting and who provide care for organization members only as a result of members being directed to the hospital or another inpatient setting.

Behavioral Health Provider Type: ___**INDIVIDUAL** ___**FACILITY** **Product**: MEDICAID

Credentialing Contact: _____ Credentialing Contact Phone #:_____

Submitted	Practitioner, Ancillary/Facility Documents	Rec'd	Comments
	Contract – 2 signed originals		
	W-9		
	Medicaid ID #		
	Practitioner Additional Documents		
	CAQH ID# (CAQH application must include all items noted below) or		
	Iowa Universal Practitioner Application - completed, signed and dated		
	State Medical License(s)		
	DEA Registration Certificate(s) (if applicable)		
	CDS/CSR Certificate (s) (if applicable)		
	ECFMG # Certificate (if applicable)		
	Malpractice Insurance Face Sheet		
	Board Certification(s) – (if applicable)		
	Professional Certification(s) (if applicable) – Midlevel Practitioners		
	Admitting Arrangements – required for mid-level providers (NP/PA) and practitioners who do not have admitting privileges		
	Collaborative Agreement – required for mid-level practitioners (NP/PA) denoting the Supervising Physician and the responsibilities of the Supervising Physician and the NP/PA.		
	CV (Resume) covering 5 yrs. of work experience with no gaps – provide explanation of gaps greater than 6 months		
	Practitioner Data Form/Roster/Enrollment form (if applicable)		
	Ownership disclosure (if applicable)		
	CLIA # (if applicable)		
	Ancillary/Facility Additional Documents		
	Iowa Universal Facility Application – completed, signed and dated		
	Accreditation or CMS Survey		If provider is not accredited and has not had a CMS Survey, a Plan Site Visit must be completed.
	Malpractice Insurance Face Sheet		
	Facility License/Business Permit		
	Ownership disclosure (if applicable)		

Please contact your Account Executive (AE) at the number located below to check the status of your application or if you have any questions and/or concerns regarding this process.

AE: _____ A.E. Phone #: _____