Provider Credentialing Checklist

Only complete submissions will be accepted.

Residency/Fellowship must be completed prior to submission of credentialing application.

Provider Name: _____

Provider Office Name: _____

Tax ID Number: _____

IPA Code: _____

	Provider	PRS/CS	Credentialing
CAQH (applicable to all MDs, DOs, DPM's, PsyDs, and DCs)			
Health Alliance Attestation Form	☐	☐	☐
Health Alliance Provider Addition / CAQH Form	☐	☐	☐
W-9	☐	☐	☐
Copy of license	☐	☐	☐
Curriculum Vitae (resume)	☐	☐	☐
Non-CAQH (applicable to all MDs, Dos, DPMs, PsyDs, and DCs who do NOT participate in CAQH)			
Applicable State Credentialing Application	☐	☐	☐
Health Alliance Attestation Form	☐	☐	☐
Copy of State License	☐	☐	☐
Copy of Current Controlled Substance License	☐	☐	☐
Copy of DEA Certificate	☐	☐	☐
Copy of Current Certificate of Insurance (COI) (with policy limits)	☐	☐	☐
Copy of Diplomas or Certification	☐	☐	☐
W-9	☐	☐	☐
Curriculum Vitae (resume)	☐	☐	☐
Explanation of Malpractice Cases (include any/all malpractice cases, license sanctions or other adverse actions from beginning of career)	☐	☐	☐
Midlevel Providers			
Applicable State Credentialing Application OR	☐	☐	☐
Health Alliance Credentialing Application	☐	☐	☐
Health Alliance Attestation Form	☐	☐	☐
Copy of State License	☐	☐	☐
Copy of Current Controlled Substance License	☐	☐	☐
Copy of DEA Certificate	☐	☐	☐
Copy of Current Certificate of Insurance (COI) (with policy limits)	☐	☐	☐
Copy of Diplomas or Certification	☐	☐	☐
W-9	☐	☐	☐
Curriculum Vitae	☐	☐	☐
Explanation of Malpractice Cases (include any/all malpractice cases, license sanctions or other adverse actions from beginning of career)	☐	☐	☐

Health Alliance Use Only:
(USVA, Provider Name, Provider Degree, PRS Name, Clean Application Date)