Client Information for Credentialing

Please send completed form to fentonrivka@gmail.com. We will be in touch.

Please check which services you are requesting:
__ NPI and TIN registration
__CAQH registration
__Credentialing and Contracting

(You may skip information that is not applicable to you.)

PROVIDER'S PERSONAL INFORMATION

Last Name(legal name) _____
First Name _____
Any other names used in the past _____
Birthdate _____ Social Security number _____
Gender _____ Ethnicity _____
City, State, Country of birth _____

SPECIALTY

Type of Provider / Specialty _____
Secondary specialty if applicable_____
Provider title (MD, RDN, etc) _____

LICENSE AND CERTIFICATIONS

License _____ License Number _____
License Effective Date _____ State Issued _____

Any Additional Certifications _____
Certification number _____ Effective date _____
Certifying agency (The name of the organization or group that issued the certification.) _____
State ____
**Please list any additional licenses and certifications at the end of this form.

Federal DEA number*_____State of registration_____
DEA issue date _____DEA expiration date_____

CDS certificate number*_____State of registration_____
CDS issue date_____CDS expiration date_____

*If applicable

Medicaid number (if you are already enrolled)_____
Medicare number (if you are already enrolled)_____
Worker's Compensation number (if applicable)_____
Taxonomy code_____

HOSPITAL AFFILIATIONS
Name of hospital_____
Address of hospital_____
Phone of hospital_____Fax of hospital)_____

EDUCATION
College attended _____
Degree _____ Degree type (ex. MS, PHD) _____
Dates attended _____Year Graduated _____
Address of college_____
Phone of college _____Fax of college_____
**Please list additional colleges at the end of the form.

Internship attended_____
Dates attended _____Year finished_____
Address of internship_____
Phone of internship_____Fax of internship_____

Residency attended* _____
Dates attended_____ Year finished_____
Address of Residency_____
Phone of residency_____Fax of residency_____
*if applicable

**Please list additional internships or residencies at the end of the form.

BUSINESS
Business name _____
Type 1 / individual NPI _____
Type 2 / group NPI _____
Tax ID number _____
CAQH provider ID _____
CAQH attestation date _____

LIABILITY INSURANCE
Name of Insurance Company _____
Name of insured _____
Policy Number _____ Effective Date _____

BANK ACCOUNT (This section is only for employers.)
Name of Bank _____ Type of account _____
Bank Address _____
Account Number _____ Routing Number _____

CONTACT
Physical Address _____
Mailing Address _____
Phone Number _____ Fax Number _____
Email Address _____
Website _____
** Please list any additional contact information at the end of the form. (Including any service or billing addresses)

MISC
Offered services _____
Business hours _____
ADA accessible? _____ TTY accessible?_____
Completed Cultural Competence Training (Cultural Diversity)? _____

Age range of patients _____
Additional spoken languages aside from english _____
Do you offer telehealth services?_____
If yes, is it on a HIPPAA compliant platform?_____

DOCUMENTS
Please send the following documents:
Picture(s) of License(s)
Picture(s) of Certification(s)
W9 Form (employee should submit employer's W9 form)
Liability Insurance
TIN Document (employers only)
Articles of Organization (employers only)
SDAT number (employers only)

INSURANCE COMPANIES

Insurance Name	Website	Indicate if Medicare or Medicaid HMO
