Sample Initial Client/Provider Set-Up Checklist

The checklist must be completed in its entirety before returning to XXX Company Provider Enrollment Team for Processing to Payer Networks.

Client Name:					
Provider Legal Name:					
Permission to Contact Provider:		Provider Phone:			
Anticipated Start Date:		Primary Location:			
Provider Type:		Practitioner Type:		Identify Other:	
Gender:		DOB:		SSN:	
Driver's License # or Gov. ID #		State:		Exp.:	
Contact Phone:		Contact Office #:		Contact Fax #:	
Contact Cell:		Email:			
Home Address:					
City/State/Zip:					
Office Contact Name:		Phone:		Email:	

NPI #:		TIN #:		PTAN #:	
CAQH ID #:		Username:		Password:	
PECOS/NPPES ID:		Username:		Password:	

Collaborating Physician:		Specialty:	
Address:		City/State/Zip:	
Phone:		Email:	

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Documents Copies Required	Requested	Check Rec. / Indicate Date Rec.	
Current CV in **mm/dd/yr format**	✓	☐	
Driver's License or Government Issued Photo ID	✓	☐	
State Mandated Application (Current) or Requested Application	✓	☐	
State Licenses (ALL)	✓	☐	
Current State Controlled Substance License	✓	☐	
Current DEA Registration	✓	☐	
Client Name:	✓	☐	
Certificate of Professional Liability Insurance	✓	☐	
Medical School Diploma	✓	☐	
ECFMG (If Applicable)	✓	☐	
Internship (If Applicable)	✓	☐	
Residency (If Applicable)	✓	☐	
Fellowship (If Applicable)	✓	☐	
Board Certification or Proof of Eligibility	✓	☐	
Continuing Medical Education	✓	☐	
Other Certifications, BLS, ACLS, PALS, etc.	✓	☐	
Peer References (3 from outside the practice)	✓	☐	
Identify and Explain any Gaps in Service	✓	☐	
Provide a list of Hospital Affiliations and Admitting Privileges	✓	☐	
Provide a list of Practice Locations and Addresses	✓	☐	
Practitioner Self-Query NPDB	✓	☐	
Collaborating Agreement (signed and dated)	✓	☐	
Other	✓	☐	

Payer Signature Requirements (Must be completed and returned within 5 business days)	**Date To Client**	**Date Received**
Current CV in **mm/dd/yr format**		
Driver's License or Government Issued Photo ID		

Sample Initial Client/Provider Set-Up Checklist

The checklist must be completed in its entirety before returning to XXX Company Provider Enrollment Team for Processing to Payer Networks.

☐ The Client approves XYZ Company Provider Enrollment Specialist to collaborate directly with the practitioner as needed to help expedite the enrollment process.

☐ I/We understand and release XYZ Company from any liability for any potential lost revenue that said provider may incur should they see and/or treat patients prior to receiving an effective participation date with non-participating payers for which XYZ Company has been engaged to conduct the timely enrollment.

☐ I/We attest that the attached list of payers is accurate and correct for which to enroll providers.

☐ I/We attest that the list of locations is accurate and correct for which to enroll providers.

☐ I understand that without identifying the list of payers for enrollment that XYZ Company will not initiate payer enrollment process.

The above requested information and documents for our new provider(s) has been reviewed and attached as requested by XYZ Company unless otherwise documented.

_____ _____

Client Signature Date

XYZ COMPANY BELOW THIS LINE

☐ I have reviewed this checklist and have noted those items highlighted in yellow as incomplete. This document will be returned to the client for completion prior to conduction the enrollment process.

☐ I have reviewed this checklist and confirm that all requested information and documentation has been received in its entirety. The enrollment process will be initiated within 10 business days.

The above requested information and documents for the client's new provider has been received in accordance to this checklist unless otherwise indicated by the client

_____ _____

XYZ Company Client Representative Signature Date