CENTRACARE Health

CentraCare Facility and Clinic Credentialing Request Form

Please complete the following information form for all new or purchased/acquired facilities and clinics needing credentialing with payers. Sections 1,2, and 4 need to be completed for all sites before the credentialing process can begin. If the site has been purchased/acquired by CentraCare Health, Sections 3A and 3B need to be completed as well.

Section 1: Information needed to request NPI:

Legal Name ____

DBA Name ____

Specialty/Location Type:_____________________________

Physical Address: ___________________________________

____

Practice Location Phone: ______________________________

Practice Location Fax: ________________________________

Section 2: Additional Information Needed for Credentialing

Effective Date of Location: _________________________

Is Urgent Care available at this location? ___Yes ___No

If yes, complete the Urgent Care section in the Hours of Operation table.

Are there any age restrictions at the site? If yes, please list.

____

Will site be accredited? ___Yes ___No

Accrediting Agency: ____________________________________

Hours of Operation:

Day of Week	Regular Hours	Urgent Care
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Contact Information:

Title	Name	Telephone	Email Address
Administrator/Facility Site Manager			
Director of Nursing/ Nursing Supervisor			
Medical Director/ Chief of Staff			

Please provide a brief description of services that will be provided at this location:

____

____

____

____

Please complete Sections 3A & 3B if the facility/clinic needing credentialing was purchased/acquired by CentraCare Health.

Section 3A: Old Site Information

Legal Name ____

DBA Name ____

Tax ID: ____

Tax Exempt? ___Yes ___No

NPI: _____________________________

MN Tax ID: ________________________

Ownership Type:

___Non-Profit ___For Profit ___Corporation ___LLC

Practice Location Phone: ______________________________

Practice Location Fax: __________________________________

Physical Address: ____________________________________

____

Billing Address: _____________________________________

____

Section 3B: Additional Documentation:

Please submit current copies of the following documents:

- Facility License
- Facility DEA
- CLIA Certificate
- Accreditation Certificate OR Most Recent CMS Survey (if not accredited)

Section 4: Provider Roster

Please submit a current provider roster with the following information in Excel format. This will be submitted with the facility paperwork to link current providers to the new site information.

- Full Legal Name
- Social Security Number
- NPI
- Gender
- Title/Degree
- Date of Birth
- License Number
- License State
- DEA Number
- DEA State
- Accepting New Patients (Y or N)
- Specialty

For Completion by Revenue Cycle:

Type of claim form used for billing: ____UB _____1500 ____Both

Billing Address: _________________________

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