New Provider Check-List

Provider: _____

Specialty: _____

Practice or Group Name: _____

If PCP, are they joining an existing group? Yes No

If a Group, is a roster of all Providers included? Yes No

Prior to the submission of an application for the credentialing of a provider, the following check list must be completed. If anything is missing the application will be considered incomplete and will not be processed. The signature date must not be older than 2 weeks from the date the complete application is submitted for processing.

___ Social security number

___ Date of birth

___ Education complete

___ Foreign Education - ECFMG

___ Primary specialty information

___ Work history complete

___ Hospital privileges complete if applicable

___ References complete

___ Call coverage complete

___ W-9

___ TPI ___ NPI

___ Practice location complete

___ questions 1-23 complete

___ Pages 11-12 compete

___ Attachments A-G included

___ Addendum included

___ Addendum included for Mid Level Professional if applicable

___ Copy of Texas license

___ Copy of DEA/DPS if applicable

___ Copy of insurance

___ Copy of CLIA / X - Ray Cert.

To be completed by Driscoll Health Plan:

Name on contract:_____
Contract reimbursement rate:_____ Contract Template Type:_____

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