CREDENTIALING CHECKLIST

IMPORTANT:
PLEASE KEEP APPLICATION IN ORDER AND UTILIZE THIS CHECKLIST TO ASSIST WITH COMPLETING YOUR APPLICATION. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.

The information requested is required by the Texas Departments of Health and/or Insurance and is based on standards established by any of the following organizations: NCQA (National Committee on Quality Assurance), JCAHO (Joint Commission on Accreditation of Healthcare Organizations), and QARI (Quality Assurance Review Initiative).

- ☐ Texas Standardized Credentialing Application **(Revision 01/07)**
- ☐ If applicable, explanation of any pending or settled malpractice cases during the last FIVE years **(REQUIRED)**;
- ☐ Initialed, Signed and Dated Attestation Pages 11 & 12 **(REQUIRED)**;
- ☐ Education (**REQUIRED) *Indicate both month and year for period attended**;
- ☐ Work History (**REQUIRED) *Include explanation for gaps of more than six (6) months**)
- ☐ Letter from Supervising Physician confirming supervision of applicant's responsibilities **(REQUIRED for Physician Assistant and Nurse Practitioner and Certified Nurse Midwife.)**
- ☐ Copy of current State license **(REQUIRED);**
- ☐ Copy of current DEA certificate **(REQUIRED);**
- ☐ Current Board Certificate(s) **(IF APPLICABLE)**; **RECERTIFICATION DATE AND EXPIRATION DATE REQUIRED**
- ☐ Copy of the ECFMG Certificate **(IF APPLICABLE)**.
- ☐ Current CLIA certificate for each practice location **(YES or NO answer is REQUIRED. If YES, submit certificate)**;
- ☐ Current TDH Radiology (X-Ray) certificate for each *practice* location (YES or NO answer is REQUIRED. If YES, submit certificate*)*;
- ☐ Current copy of Malpractice Insurance Face Sheet **(REQUIRED)**;
- ☐ Current copy of W-9 **(REQUIRED) *Must reflect exact "bill pay to"**;
- ☐ Demographic Information Form **(REQUIRED) *Need for Provider set-up**;
- ☐ Current Curriculum Vitae (**IF APPLICABLE) *Indicate both month and year**
- ☐ EPSDT/THSteps Number **(IF APPLICABLE);**
- ☐ NPI – National Provider Identifier **(REQUIRED)**
- ☐ If you are a Medicaid provider, please include your TPI numbers and effective dates, both individual and group. (**REQUIRED for participation in Medicaid Plans)**

NOTE: AN APPLICATION CANNOT BE PROCESSED IF FIELDS ARE LEFT BLANK; PLEASE USE "N/A" IF NOT APPLICABLE. ALL LICENSES/CERTIFICATES MUST BE CURRENT AND SUBMITTED ALONG WITH THE APPLICATION IN ORDER TO GET PROCESSED.

APPICATION CAN BE MAILED, EMAIL OR HAND DELIVERED. MAIL TO:

El Paso Health
PO Box 971100
El Paso, TX 79997-1100

Please call *915 298-7198 ext. 1005* for email and physical address. Sorry faxes are not accepted

Completion of this application does not constitute approval or acceptance of participating status in El Paso Health.