For Administrative Use ONLY

Recredentialing Due Date: **Prior Recredentialing Date:**

Initial Credentialing Date: **Credentialing Start Date:**

Credentialing Completion Date: **Credentialing Decision Date:**

Organizational / Specialized Residential Provider File:

Initial ☐
Recredentialing ☐

PROVIDER NAME, ADDRESS and PHONE:

Is application obtained from another participant CMHSP: ☐

	Date Received	Date Reviewed	Date of 2nd Review
Organizational application and attestation			
Date of provider signature			
Copy of state license/certification (List with expiration date)			
Primary Source verification of license			
Quality Data check/ PI information (site review info/score) Plan of Correction?			
Copy of insurance w/exp. Date - Is CMH an additional insured? Yes / No ☐General Liability $1M ea occurrence $2M gen aggregate ☐Auto ☐Worker's Comp ☐Employer's Liability $500,000 ea accident/disease ☐Prof Liability $1M ea occurrence, $3M aggregate			
OIG sanctions list verification			
MDHHS Sanctioned Provider list verification			
SAM verification			
Program Certification (Clubhouse and Crisis Residential) or ASAM LOC (SUD Providers) as applicable			
Copy of TJC, CARF, COA, AOA, MARR, NCQA, BHCOE DNV report. Date of expiration:			
NPI Verification			
Tax ID # / W-9			
G&A data base information (Rights)			
Clinical Code of Ethics			

QI Data Check (Required for Recredentialing Only)			
1. Compliance F/W/A or other billing issues: ☒ No issues reported. ☐ Issues reported [insert summary]			
2. Customer Services Issues (Other than formal Grievances / Appeals: ☒ No issues reported. ☐ Issues reported [insert summary]			
3. Utilization Management ☒ No issues reported. ☐ Issues reported [insert summary]			
Date file complete			
Application was signed/dated no more than 180 days prior to credentialing committee review?	Y☐ N☐		
Primary/secondary source verification occurred no more than 6 months prior to credentialing committee review?	Y☐ N☐		
Clean file reviewed by Medical Director **Date:**	Y☐ N☐		
Date of Credentialing committee decision: **(N/A if clean file reviewed and approved by Medical Director)**			
Provider notified of credentialing status			
Re-credentialing required by:			
HCBS Provisional Approval Date: CMHSP:			
Minutes from Credentialing Committee Meeting or Email			

Initial file review completed by: _____ Date: _____

Second file review completed by: _____ Date: _____

Approved by Medical Director: _____ Date: _____