MED CREDENTIAL PRO, LLC

https://medcredentialpro.com/

PRACTICE INFORMATION							
Group/Clinic Name (DBA):							
Name of EIN/TIN Registered with the IRS:							
Name of Owner(s):			Percentage of Ownership:				
Office Hours:	Monday _____-_____	Tuesday _____-_____	Wednesday _____-_____	Thursday _____-_____	Friday _____-_____	Saturday _____-_____	Sunday _____-_____
Practice Limitations:	Minimum Age:	Max Age:	Gender Limitation: Male		ADA Accessibility requirements met? Yes No		Handicapped Acessible? Yes NO
Language spoken at office:							
Physical Address:							
City:			State:		Zip Code:		
Phone:			Fax:				
Office Contact Name:			Office Contact Email:				
Billing Address (or specify if DAI billing client):							
City:			State:		Zip Code:		
Phone:			Fax:				
Billing Contact Name:			Billing Contact Email:				
Correspondence Address:							
City:			State:		Zip Code:		
Phone:			Fax:				
Correspondence Contact Name:			Correspondence Contact Email:				
Medical Record Address:							
City:			State:		Zip Code:		
Phone:			Fax:				
Medical Records Contact Name:			Medical Records Contact Email:				

CREDENTIALING INFORMATION		
TID:	Group NPI:	Group Medicaid ID:
Group Medicare PTAN:	Railroad Medicare PTAN:	CLIA:
NPPES/PECOS User ID:	NPPES/PECOS Password:	
Specialty:	Taxonomy Code:	

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HOSPITAL AFFILIATIONS (List Facility: Name, Address, Type of Privileges, Effective date of Privileges)

REQUIRED MATERIALS
PLease Supply a copy of all of the folowing documents that apply: • Tax ID verification letter from the IRS • Occupational License (If applicable) • Acreditation (If applicable) • Current Malpractice Polley • Voided Check/Bank Letter • W9 • Explanation to any licensures or clinical privileges ever being suspended, revoked, modified or restricted • Explanation to any Malpractice cases • Provide a list of any Managed Care Plans you are currently contracted with listing effective dates of contracts.

AUTHORIZED OFFICIAL(S) (Copy Page and submi for EACH authorized official)	
Name:	
SSN:	**Cell Phone:**
Home Address:	
NPPES Login ID:	**NPPES Password:**
I authorize Doctor's Advantage to use my signature below for credentialing purpose.	**Initials. __ _**
Signature of authorized signer for Group/Clinic (Please Keep Signature inside box) ** PLEASE USE SHARPIE OR ELECTRONIC SIGNATURE**	**Date:**