Credentialing Application Checklist

As a provider in CAQH please submit per provider:

- ☐ Complete W-9, at least one in all providers share same tax ID
- ☐ CAQH Provider Date Form FULLY COMPLETED for each individual Provider
- ☐ Completed and signed Disclosure of Ownership and Control Interest Statement

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If you are not participating with CAQH please contact us for a credentialing application.

If submitting credentialing applications for greater than five providers, you may request an electronic roster form.

meridian

CAQH Provider Data Form

For Credentialing Purposes

Date:		Are you registered with CAQH? __Yes __No	
If Yes, CAQH Provider ID:		Individual NPI:	
Last Name:		First Name:	Middle Name:
Date of Birth:	Gender:	Social Security:	Medicaid ID #:
Provider Type (MD, DO, PhD, LCSE, LPC, etc.):		Are you a hospital based only provider not practicing in an office setting? __Yes __No	
Tax ID:		Group Billing NPI:	
Practice Name:		Email Address:	
Primary office Street Address:			Suite #:
Primary Office City:		State:	County: Zip:
Primary Telephone:		Primary Fax:	
Credentialing Contact Information:			

Specialty:	Applying As: __Specialist __Primary Care Provider	
If PCP, are you accepting new patients? __Yes __No __Yes, existing patients only	What gender or age restrictions do you have? Gender: __No Restrictions __Female Only __Male Only Age: __No Restrictions __Age Limits: Lowest Age___ Highest age___	
Are you board certified? __Yes __ No	If Yes, Board Name:	Exp. Date:
Please list any medical related organizations you have ownership with, e.g., laboratory, home health agency, radiology facility, mobile testing, MRI, etc.:		
If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificates or waiver if you have one.		

Do you have a CLIA Certificate? __Yes __No	Do you have a CLIA Waiver? __Yes __No	Type of Service Provided:
Certificate Number: Certificate Expiration: Date:		CLIA Name: Tax ID:

Note: If you have already completed your application with CAQH, please ensure that you have authorized Meridian to access your data. This can be done by calling CAQH at **888-599-1771** or by logging into your account and adding Meridian to your list of authorized plans. Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with Meridian.

Disclosure of Ownership and Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are executing a provider agreement or submitting a provider application to disclose to managed care organizations that contract with the state Medicaid agency: 1) the identity of all persons with an ownership or control interest (e.g., has an ownership interest of 5% or more in a disclosing entity, is an officer or director of a disclosing entity organized as a corporation or a partner of a disclosing entity organized as a partnership, owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity under certain circumstances, etc.), 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this Statement, an updated Statement should be completed and submitted to within 30 days of the change. Please attach a separate sheet if necessary to provide complete information. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network.

Practice Information

Check one that describes you: ____Individual Provider ____Group Practice ____Disclosing Entity	
Name of Individual Provider, Group Practice, or Disclosing Entity ("Provider")	
DBA Name:	
Address:	
TIN or SSN:	NPI:

Section I: Provider Ownership and Control Interest

For individuals with an ownership or control interest in the provider (e.g., an ownership interest of 5% or greater, an officer or director of a Disclosing Entity that is a corporation, etc. – refer to the definition of "person with ownership or control interest" in the instructions), list the name, address, date of birth (DOB), and Social Security Number (SSN) for each such individual.

For entities with an ownership or control interest in the provider, list the name, Tax Identification Number (TIN), and address of each entity. (42 CFR 455.104) Attach a separate sheet if necessary.

Name	DOB (if an individual)	Address	SSN (if an individual) TIN (if an entity)

Section II: Subcontractor Ownership and Control Interest

Are there any subcontractors in which the provider has an ownership or control interest of 5% or more? __Yes __ No

If "yes," list the name, address, DOB, and SSN for each individual having an ownership or control interest in such subcontractor(s), and list the name, TIN and each address for each entity having an ownership or control interest in such subcontractor. (42 CFR 455.104) Attach a separate sheet if necessary.

Name	DOB (If an individual)	Address	SSN (if listing an individual) TIN (if listing an entity)

Disclosure of Ownership and Control Interest Statement

Section III: Relationships

Are any of the individuals listed in Section I or Section II above related to each other? __Yes __No
If yes, list the individuals who are related to each other, and the type of relationship (i.e., spouse, sibling, parent, child). (42 CFR 455.104) Attach a separate sheet if necessary.

Name	Type of Relationship

Section IV: Convictions

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the providerever been convicted of a crime related to that person's involvement in any program under Medicaid or Title XX program? __Yes __ No (verify through OIG website)
If "yes," please list those persons below. (42 CFR 455.106) Attach a separate sheet if necessary.

Name/Title	DOB	Address	SSN

Section V: Business Transactions

Has the provider had any financial transactions with any subcontractors totaling more than $25,000 with any subcontractors during the previous 12 months? __Yes __No

Has the provider had any significant business transactions between it and any wholly owned supplier or any subcontractor during the previous five years? __Yes __No

If yes, list the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the previous twelve-month period, and any significant business transactions between the Provider and any wholly owned supplier or between the provider and any subcontractor during the past five-year period. (42 CFR 455.105). Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI: Managing Employees

Does the provider have any managing employees? __Yes __No
If yes, list each member of the Board of Directors or Governing Board and each managing employee with their name, DOB, address, SSN, and percent of interest. (42 CFR 455.104) Attach a separate sheet if necessary.

Name/Title	DOB	Address	SSN	%Interest

Disclosure of Ownership and Control Interest Statement

If “Group Practice” or “Disclosing Entity” is checked in the Practice Information section above, the undersigned hereby represents that he, she or it is providing the information in this Statement on behalf of the Group Practice or Disclosing Entity, as appropriate,and on behalf of each provider and provider listed on Exhibit A attached to this Statement, and the undersigned represents thathe, she or it is legally authorized, as an agent or attorney-in-fact, to provide such information and execute this Statement on behalf of the Group Practice or Disclosing Entity and each listed provider and provider.

The undersigned certifies that the information provided herein, is true, accurate and complete. Additions or revisions to the information above will be submitted immediately after such change. Additionally, the undersigned understands that misleading, inaccurate, or incomplete data may result in a denial of participation for the affected providers.

Signature	**Title (or indicate if authorized Agent)**
Name (please print)	**Date**

Provider Directory Required Data Survey

Please include the below information for providers who will be appearing in the Meridian Provider Directory.

Provider Tax ID Number (TIN): _____

Provider Group NPI: _____

Practice Location Name: _____

Practice Location Address: _____

Practice Location Phone: _____

Practice Email: _____

Practice Website: _____

Practice Location Contact Person: _____

Practice Location Hours of Operation:

Monday	_____a.m.	to	_____p.m.
Tuesday	_____a.m.	to	_____p.m.
Tuesday	_____a.m.	to	_____p.m.
Wednesday	_____a.m.	to	_____p.m.
Thursday	_____a.m.	to	_____p.m.
Friday	_____a.m.	to	_____p.m.
Saturday	_____a.m.	to	_____p.m.
Sunday	_____a.m.	to	_____p.m.

For this practice location, please specify which accessibility options you have forindividuals with physical disabilities:

	Yes	No
Parking spaces, curb ramps, or loading zones at building entrance		
Doorways wide enough to ensure safe passage by individuals using mobility aids		
Wheelchair accessible restrooms with grab bars and accessible lavatories		
ASL signage and raised tactile text characters at office, elevator, and restroom doors		

Medical equipment accessible to patients using mobility aids		
Exam rooms accessible to patient using mobility aids		
Other		

Is the provider's location on an accessible public transportation route?

	Yes	No
Bus		
Rail		
Other		

Does this location offer non-English languages (including ASL) on-site by qualified healthcare interpreters?

☐ Yes ☐ NO

If the answer is yes, which non-English languages are provided on-site by qualifiedhealthcare providers, office staff and or interpreters at this location?

	Yes	No
American Sign Language (ASL)		
Arabic		
Cantonese		
French		
German		
Haitian		
Hindi		
Italian		
Japanese		
Korean		
Mandarin		
Polish		
Portuguese		
Russian		
Spanish		

Tagalog		
Vietnamese		
Other		

Has the provider completed cultural competency training? If the answer is "Yes," please complete the below chart:

	Yes	No
African American		
Alaskan Native		
American Indian		
Asian		
Hispanic/Latino		
Pacific Islander		
Other		

Does the provider have specialized training and experience in treating the following?

	Yes	No
Physical Disabilities		
Intellectual and Developmental Disabilities		
Chronic Illness		
HIV/AIDS		
Serious Mental Illness		
Substance Abuse		
Homelessness		
Deafness or hard-of-hearing		
Blindness or Visual Impairment		
Co-occurring Disorders		
Other		

Does the provider support electronic prescribing?

☐ Yes ☐ No

Does the provider supply translation services for written materials?

☐ Yes ☐ No

Is the provider accepting new patients?

☐ Yes ☐ No

Please provide the following information for each of the providers that work at this practice location:

Provider First Name	Provider Last Name	Provider Individual NPI

I hereby certify the above information to be true and correct to the best of myknowledge.

_____ _____

Signature Date

_____ _____

Print Name Title