P3 Health Partners
People. Passion. Purpose.

Corporate Credentialing Department
2370 Corporate Circle #300
Henderson, NV 89074
Ph (702) 910-3950
Fax (702) 778-2264

CREDENTIALING APPLICATION CHECKLIST

It is critical that all the below elements on this checklist are returned with P3 credentialing application OR uploaded in CAQH so we are able to pull from your profile.

	Complete the 3-page Application Form including date and signature ***(signature from provider ONLY)***. CAQH must be updated/re-attested within the last 90 days of sending to P3 Credentialing. If a provider is not registered with CAQH, please register or attach a fully completed Provider Standard Application for your market. *Please do not leave anything blank. If something does not apply, please put N/A.*
	Copy of current W9 with group's legal name on file with IRS
	Copy of Professional License
	Copy of current DEA license issued in the state where the provider is practicing *(if applicable)*
	Copy of Pharmacy license *(if applicable)*
	Copy of Education/Degree Diploma(s)
	Copy of Specialty Board Certification *(if applicable)*
	Copy ECFMG Certificate / Fifth Pathway Document *(if applicable)*
	Copy of current malpractice Insurance
	Legal documents and/or the provider's explanation for ***ANY*** pending/settled malpractice claims / board actions
	Work History for the past 5 years *(including current)* ***MUST*** be listed with ALL gaps explained *(on Application, in CAQH or CV)*

(Please use this checklist as a guide)

Credentialing Application / Information Form for NV Network Medical Practitioners

Thank you for your interest in becoming a contracted provider. In order to complete the contracting process with the P3 Health Partners Network, you must sucessfully complete the credentialing process.

REQUIRED: **Professional providers are required to register with CAQH and complete a provider profile to be used for initial credentialing and subsequent renewals.**

1) **Register with CAQH and complete your provider profile** - Register for free and complete your profile online at: *ProView.CAQH.org*
2) **Authorize P3 Health Partners to access information -** Use the "Authorize" section in ProView to authorize P3 to access your information
3) **Provide your CAQH provider ID number -** Enter your CAQH provider ID number in the firsh field of the form below
4) **Complete the P3 Application Form** - Complete the entire form below and then save, attach and email the form to: P3Credentialing@p3hp.org
5) **Update CAQH regularly -** Review, update with changes and re-attest your CAQH provider file as required quarterly.

The completion of this application / information form does not guarantee network participation. Additional documentation may be required to validate and provide detail on some responses.

NOTE: *Files are not considered complete until all information is received. Incomplete files will not be accepted. See attached checklist for required items.*

CAQH Provider ID *(Required)*	CAQH Provider ID Number			
PROVIDER NAME and DEGREE *attach a copy of your Degree(s)* *(Required)*	Last	First	MI	Degree (MD, DO, Etc)
	Gender	Date of Birth (mm/dd/yyyy)	SSN	Birth Place (City & State)
OTHER NAME(S) USED	Last	First	MI	
INDIVIDUAL NPI *(Required)*	Individual NPI	Effective Date (mm/dd/yyyy)		
MEDICAL LICENSE *attach a copy of you medical license* *(Required)*	License Number	Effective Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	

OTHER ID NUMBERS *attach copy(s) of all licensure* *(Required)*

DEA # ____________________ Expiration Date: _____ / _____ / __________

Pharmacy/CS # ____________________ Expiration Date: _____ / _____ / __________

Medicare PTAN # ____________________

Medicaid # & State ____________________

ARE YOU ACCEPTING NEW PATIENTS? *(Required)* ☐ YES ☐ NO

ARE YOU A PCP? (ARE PATIENTS TO BE ASSIGNED/PANELLED TO YOU) *(Required)* ☐ YES ☐ NO

GROUP NAME Claim payments may be made to the Group Name / NPI Number *(Required)*	Group Legal Name - as on file with the IRS		
	Group DBA (Doing Business As) Name		
	Group / Organization NPI		
TAX ID and START DATE *(Required)*	Tax ID Number	Date when group started billing with this Tax ID #	
OFFICE CONTACT *(Required)*	Name	Title	
	Office Contact Email Address	Phone	Fax

SPECIALTY / TAXONOMY Please note, what you indiciate as your practicing specialty(s) will be how you are listed in the P3 Health Partners directories *(Required)*	Check applicable box	☐ Hospital Based	☐ Office Based
	Primary Practicing Specialty		
	Other Practicing Specialty(s) as applicable		
	Individual Taxonomy		
SPECIALTY BOARD CERTIFIED If YES, please attach a copy of Board Certificate *(Required)*	Board Certified?	☐ YES	☐ NO
	Name of Specialty Board		Certificate #
	Certified (mm/dd/yyyy)	Recertified (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)
ADDITIONAL SPECIALTY BOARD CERTIFIED If YES, please attach a copy of Board Certificate *(Required)*	Board Certified?	☐ YES	☐ NO
	Name of Specialty Board		Certificate #
	Certified (mm/dd/yyyy)	Recertified (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)
INDIAN HEALTH CARE *(Required)*	Are you an Indian Health Care Provider?		
	☐ YES	☐ NO	
OTHER LANGUAGES SPOKEN BY PROVIDER	1)	2)	3)

HOSPITAL/SNFs/SURGERY FACILITY PRIVILEGES *(Required)* If space for additional facilities is needed, please attach a separate sheet.

FACILITY NAME:	**PRIVILEGE TYPE:**
FACILITY ADDRESS	**FACILITY PHONE:**
FACILITY NAME:	**PRIVILEGE TYPE:**
FACILITY ADDRESS	**FACILITY PHONE:**
FACILITY NAME:	**PRIVILEGE TYPE:**
FACILITY ADDRESS	**FACILITY PHONE:**
FACILITY NAME:	**PRIVILEGE TYPE:**
FACILITY ADDRESS	**FACILITY PHONE:**

BUSINESS WEBSITE *(Required)*	Website:
BUSINESS EMAIL *(Required)*	Provider Business Email (contracts and coorespondence must be sentnto the provider, not to a billing company or a consultant)

PRIMARY ADDRESS Primary address must be a physical location where services are performed. *If there are additional locactions, attach a separate sheet.* *(Required)*	Street Address						Suite	
	City				State		Zip	
	Phone				Fax			
	Office Hours	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
	Start time							
	End Time							

BILLING ADDRESS Contracted provider payments will be sent to this address *(Required)*	Street Address		Suite
	City	State	Zip
	Phone	Fax	

MAILING ADDRESS If no address is specified, correspondence will be sent to the billing address	Street Address		Suite
	City	State	Zip
	Phone	Fax	
CREDENTIALING COORESPONDENCE If no address is specified, correspondence will be sent to the billing address	Street Address		Suite
	City	State	Zip
	Phone	Fax	
MEDICAL RECORDS If no address is specified, correspondence will be sent to the billing address	Street Address		Suite
	City	State	Zip
	Medical Records Email	Phone	Fax

ADDITIONAL INFORMATION / COMMENTS:

I, ____ ***(name & title),*** verify that the information provided on this form and in CAQH is correct and complete. I agree that by signing my name in the field below, I am giving permission to access information on CAQH for Credentialing purposes..

____ ____

Provider Signature **Date**

EMAIL THE ENTIRE FORM *and* ATTACHMENTS TO: P3Credentialing@p3hp.org

Rev. 10.17.19

Initial Credentialing-Network P&P