Credentialing Solutions, Inc.

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Practitioner: ________________________ **Facility:** _______________________________

Please complete the applicable information and return documents in PDF Format.

DOCUMENT	CHECK LIST
Provider's Name:	
Provider's SSN / DOB:	
Medical License:	
Driver's License:	
DEA License:	
Diplomas: Medical, Internship, Residency and Board Certificate	
NPI Number: Individual and/or Group	Individual: Group:
Curriculum Vitae (CV):	
Tax ID (W-9):	
Office Address:	
Office Telephone Number / Fax Number:	
Contact Person:	
E-mail address:	
Cell Phone:	
Medicare / Medicaid Provider Numbers:	
"VOID" Check (for EFT)	
3 Peer References with Name, Telephone and Email:	
Business Owner Name / SSN / DOB:	
Vaccination Records	
CAQH Username:	
CAQH Password:	
Certificate of Insurance – Professional and General Liability:	
ACLS / BLS	

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