MPCR400 – Attachment B.1
PHYSICIAN Initial Credentialing Checklist
Meeting Date:

Provider Name:	PCP ☐ OB/GYN Specialist - Type:	
Cred Specialist:	Auditor:	Audit Date:

▪ Application Received Date:	Refer to Policies CR 300 & CR 400, & CR 17 if PCP

Document Title — No document may be older than 180 days.	Date Verified or NA	Verified by:	Document Expiration Date	Audit V
Confirm Specialty Exists at site (under C1)			NA	
Medi-Cal Enrollment Verification - by NPI **Source: Medi-Cal.gov**			NA	
Hire Date			NA	
License Verification **Source: CA DCA Breeze** *Secondary License Actions?* ***Y*** or **N** **Per SB137 if middle name is on Breeze, it must be added to Intelli.** CR 3A Factor 1				
DEA/CDS Certificate Suboxone **Y** or **N** (If yes, confirm addendum is behind DEA cert and board Cert and DEA screens are filled out) (must have DEA for every state provider works in) **Source: DEA CSA** CR 3A Factor 2				
Board Certification or Residency Letter *(if neither, AMA (below) is required)* • *If PCP: Family Med ☐ Internal Med ☐ Pediatrics* **Source: ABMS or ☐ AOA** • **MPCR17 worksheet**				
AMA Profile *Can be used for Residency Verification on MD/DO's (not all DO's belong to AMA)* • *Verified?* ***Y*** *or* ***N*** **Source: AMA**				
Work History -CV GAP **Y** or **N** *Must contain current 5 year work History- more than 6 month gap requires a verbal explanation/ More than 12 month gap requires written explanation from provider* CR 3A Factor 5 **Notes:**______________________________			NA	
Attestation Questions (Application/Med. Director) **Signature Date:** ▪ *Adverse Answer -* ***Y*** *or* ***N*** *if yes, what question*_______ CR 3C Factors 1, 2, 3, 4, 6 **Source**: CPPA CAQH ☐ Other ☐___________				
File Release (Malpractice History) **Application Signature Date:** *Provider name on bottom of every page of app?* ***Y*** *or* ***N***				
Hospital Privileges *Hospitalist, Admitting Agreement, Group Coverage or Transfer Agreement*				
Certificate of Professional Liability Insurance CR 3C Factor 5 ▪ *Coverage of at least 1m & 3m –* ***Y*** *or* ***N*** *If No, specify coverage:* ________________ *X Provider name on COI* ☐ *Provider name on an attached Roster* ☐ *Policy info on Application* ☐ *Provider covered by a TORT*				
NPDB (cannot be pulled/sourced until all info is entered into Intelli) ▪ Adverse Actions – **Y** or **N** **Source: NPDB-HIPDB** CR 3A Factor 6 CR 3B Factor 1 CR 3B Factor 2			NA	
Site Audit – C1 ONLY Required for PCPs and OBGYN				
Sanction Reports With Sources: ☐ Medi-Cal S&I Date: ☐ OIG Date: ☐ Data.CMS.gov Date: ☐ SAM Date:			NA	
NPI Verification (NPPES Printout) **Source: NPPES**			NA	
CCS			NA	
Start-up Documents (C1 only – verify documents are present with contract)			NA	

Reviewer Attestation:

I attest that I have reviewed this provider's credentialing application, supporting documents and primary source verifications (electronic and/or hard copy) in accordance with adopted standards/internal policies/procedures and that the information is current, correct and complete to the best of my knowledge.

Signature____ Date:___________________________________