MPCR400 – Attachment B.6
Ancillary Provider
Initial Credentialing & Re-Cred Checklist

Facility Name:	Provider Type:	
Cred Specialist:	Auditor:	Audit Date:
▪ Application Received Date: ▪ **Place a Copy of the Application Loose in Chart**		**Refer to Policies CR 700 & CR 400**

Document Title No document may be older than 180 days.			**Date of Verification or NA**	**Verified by:**	**Document Expiration Date**	Audit √
Medi-Cal Verification ***Source: Medi-Cal.gov***					NA	
Application Signature Date: _____						
W-9 (required for Initial Credentialing only)						
Business License **Source: DHCS**						
Liability Insurance *Coverage of at least 1m & 3m – **Y** or **N***						
Sanctions Reports With Sources	☐ Medi-Cal S&I Date:	☐ OIG Date:			NA	
	☐ Data.CMS.gov Date:	☐ SAM Date:				
NPI Verification (NPPES Printout) **Source: NPPES**					NA	
COPY of Application (place in the front of the chart)					NA	
All dates added to Grid – Current Meeting date/Send ReCred App						

Intelli Audit				
PHC # (re-Cred)	Facility Corporate Address, Phone & Fax Match App	License # & Exp Date Match App	Insurance Policy # & Limits Match App	Counties Listed Match App

Post Audit	Supervisor Signature:	Date:

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:_____