# MPCR400 – Attachment B.8
# Long Term Care & Skilled Nursing Facility
# Initial Credentialing & Re-Cred Checklist

| | | |
|---|---|---|
| Facility Name: | Provider Type: | |
| Cred Specialist: | Auditor: | Audit Date: |
| ▪ **Application Received Date:**<br>▪ **Place a Copy of the Application Loose in Chart** **(Initial Only)** | | **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** | | | | | | |
| **W-9** (required for Initial Credentialing only) | | | | | | |
| **State License** **Source: DHCS** | | | | | | |
| **Liability Insurance**<br>*Coverage of at least 1m & 3m – Y or N* | | | | | | |
| **Accreditation** – ***if do not have accreditation, need CMS review below*** | | | | | | |
| **CMS or Site Review** – form 2567 (if deficiencies reported, need CAP acceptance letter) | | | | | | |
| **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 | |
| **All dates added to Grid – Current Meeting date/Send ReCred App** | | | | | | |

| **Intelli Audit** | | | | | | | |
|---|---|---|---|---|---|---|---|
| PHC # (re-Cred) | Facility & Corporate Address Match App | TIN# matches W-9 or App | County Matches App | NPI# Matches App | Insurance Policy# & Limits Match App | HCFA Status "Yes" | Directories updated |
| | | | | | | | |

| | | |
|---|---|---|
| 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:_____