



PROVIDER: _____

Credentialing Contact: _____

Ph: _____ Fax: _____ Email: _____

SERVICE TYPE(S)

- Hospital Facility**
- Skilled Nursing Facility**
- Free Standing Laboratory**
- Durable Medical Equipment Supplier**
- OTHER** _____

PROVIDER CHECKLIST

- LICENSURE:** Current copies of all facility and professional staff licenses or a roster including license numbers and expiration dates.
- ACCREDITATION CERTIFICATES:** Current copies of the following, as applicable:
 - Medicare number
 - CLIA Certificate
 - Medicaid Number
 - Facility Billing NPI#
 - TJC, CARF, CHAP, NCQA letter
- W-9:** For each facility/branch with a different name please include a separate W-9.
- PROFESSIONAL/FACILITY LIABILITY INSURANCE:** Copy of certificate documenting coverage for all professional staff and/or facilities.
- ORGANIZATIONAL PROVIDER CREDENTIALING APPLICATION**
- FORM 3974 PROVIDER ENROLLMENT DISCLOSURE STATEMENT:** Please return completed form to Trillium- please do not send to DMAP.

RETURN TO

ORProviderExperience@trilliumchp.com