PHYSICIAN CREDENTIALING
(CAQH)
SUBMISSION FORM

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1. Practitioner Pin/CAQH ID#: _____
2. Practitioner Last Name: _____
3. Practitioner First Name: _____
4. Date of Birth: _____
5. Practitioner NPI Number: _____
6. Social Security Number: XXX – XX - _____
7. Practitioner Type: (Circle One) MD DO DPM DC NP /APRN / CNM
8. Specialty: _____
9. List Languages Provider Speaks _____, _____, _____-
10. Board Certification(s): 1._____
    Expiration Date: _____
    2. _____
    Expiration Date: _____
11. Group Name: _____
12. Group Physical Address: _____
    _____
13. Group Phone Number: _____
14. Paper/CAQH: Paper □ CAQH □

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15. Initial or Re-cred: Initial □ Re-cred □

16. Last Date of Attestation: _____

17. Contact Person for Credentialing _____

18. Credentialing Address _____

_____

19. Credentialing E-mail Address: _____

20. Credentialing Phone and Fax Number (P)_____ (F) _____

21. Site Visit Attached: Attached □ N/A □

22. New Provider Loaded in Database: Yes □ No □

23. Agreement received and signed: Yes □ No □

24. Provider part of existing or new group: New □ Existing □

25. EPSDT Certification for PCPs (Family Practice and Pediatrics)

Yes □ Please provide state approval letter. Failure to include the letter may result in being listed as NO for EPSDT certification.

No □ MPC encourages providers to become EPSDT Certified (Early and Periodic Screening, Diagnosis, and Testing) through the Maryland Department of Health at https://health.maryland.gov/mmcp/epsdt/pages/Home.aspx

26. Date submitted to Credentialing: _____

27. Submitted by: _____