Application Checklist for Practitioners

Keystone First
Family of Health Plans

Please use this checklist to complete the credentialing process. All items listed are required for each practitioner to participate with Keystone First, Keystone First VIP Choice, Keystone First Community HealthChoices, and/or Keystone First – CHIP.

You should use this checklist as a fax cover sheet. Fax all applicable items on this checklist to **1-877-759-6221**.
Or, you may scan your signed documents and submit them by secure e-mail to **credapps@keystonefirstpa.com**.
Please be sure to scan this checklist and fax or email it along with the documents.

Please provide the following practitioner information:		
Applicant's full name:		Title (M.D., D.O., etc.):
Practice/group name to appear in directory (doing business as [DBA]):		
Is this practice a ☐ Federally qualified health center (FQHC) ☐ Rural health clinic (RHC) ☐ Indian tribe ☐ Tribal organization ☐ Urban Indian organization		
Are you applying for Keystone First? ☐ Yes ☐ No Are you or the group you are joining contracted with Keystone First? ☐ Yes ☐ No		
Are you applying for Keystone First VIP Choice? ☐ Yes ☐ No Are you or the group you are joining contracted with Keystone First VIP Choice? ☐ Yes ☐ No		
Are you applying for Keystone First Community HealthChoices? ☐ Yes ☐ No Are you or the group you are joining contracted with Keystone First Community HealthChoices? ☐ Yes ☐ No		
Are you applying for Keystone First – CHIP? ☐ Yes ☐ No Are you or the group you are joining contracted with Keystone First – CHIP? ☐ Yes ☐ No		
Practice's Taxpayer Identification Number (TIN):	Group's National Provider Identifier (NPI) number:	Applicant's NPI number:
Individual Medicaid ID number:		
Medicare ID number (if applicable; must have a Medicare ID number in order to participate with Medicare plan):		
CAQH-issued ID number:		
☐ Primary care practitioner (PCP) ☐ Specialist	☐ Dentist ☐ Hospital-based only	☐ Allied health ☐ Allied health
Applicant's specialty:		
Credentialing contact name:	Credentialing contact email address:	Credentialing contact phone number:
*Applicant's race (choose only one): ☐ Black or African American ☐ White ☐ Asian	☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native	☐ Middle Eastern/North African ☐ Some other race ☐ Decline to say
*Applicant's ethnicity:	☐ Hispanic or Latino ☐ Non-Hispanic or Latino	☐ Unknown or decline to say
*Language(s) spoken by applicant and/or clinical staff:		

Please provide the following:
☐ CAQH authorization allowing the Plan to access practitioner information **(Please ensure all current copies of the supporting documents below are updated on the CAQH application. Do not submit until all documents are current.)**
Non-CAQH participants must submit copies of the following support documents: ☐ Practitioner application (completed, signed, and dated) ☐ State medical license ☐ Board certification (if applicable) ☐ Certifications for the following practitioners (if applicable): • (Behavioral health) Social Worker, Professional Counselor, and Psychologist • Nurse Practitioner • Physician Assistant • Nurse Midwife
☐ Drug Enforcement Administration (DEA) registration certificate (if applicable) • DEA certificate must have the state in which the practitioner is rendering services to our members.
☐ Controlled Dangerous Substances (CDS) certificate (if applicable)
☐ Malpractice insurance policy face sheet showing expiration dates and limits of liability (Provider's name must be on face sheet. If name is not included, a roster is required.)
☐ CV/résumé (if applicable) • CV/résumé must cover five years of work experience with no gaps. Provide an explanation of any gaps greater than six months.
☐ Clinical Laboratory Improvement Amendments (CLIA) certificate (if applicable)
☐ Medicaid provider enrollment number (We **must** have your PROMISe™ Provider Identification Number [PPID] number as well as a PPID number for each location, or proof that you have submitted an application. For applications in process with the Department of Human Services [DHS], please submit a copy of the first page and signature page of the application you submitted.)
☐ W-9 form
☐ Hospital privileges indicating the practitioner's primary admitting hospital Please forward a copy of a coverage agreement if the practitioner does not have admitting privileges or a letter stating hospitalist service used.
☐ Practitioner's office hours (must be completed on the application)
☐ Allied health professionals listed below are required to provide a Collaborative Agreement: • Nurse Practitioner (NP) • Physician Assistant (PA) • Osteopathic Assistant (OA) • Certified Nurse Midwife (CNM)
☐ Ownership disclosure (required)
☐ Keystone First Warranty Attestation (paper application only)

To check the status of your application, or if you have questions or concerns regarding this process, please contact the Credentialing department at **1-800-642-3510,** option **1**.

If you are new to Keystone First/Keystone First Community HealthChoices/Keystone First VIP Choice/Keystone First – CHIP and you or your group do not have a provider contract, visit **www.keystonefirstpa.com** → **Providers** → **Join our network** to obtain a contracting application.

If you are a PCP, OB/GYN, general dentist, or pediatric dentist, our Provider Network department will contact you to schedule a site visit at your office(s).