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

Trillium Community Health Plan CCO	E-mail: TCH_ProviderOperations@Centene.com
Health Net of Oregon	E-mail: HNOR_ProviderOperations@healthnet.com