BECAUSE OF YOU
MOUNT CARMEL
Health Partners

INITIAL APPLICATION CHECKLIST
FEE and PAYOR REQUIRED DOCUMENTS

Provider Name	Provider Email
CAQH ID #	Provider Cell Phone #

Current and legible PDF documents

☐	CAQH	To ensure we have access to download your CAQH application, please include Mount Carmel Health Partners and Mount Carmel Health System, if applicable to your list of Authorized Plans. The application needs to be complete and current (attested to within 30 days of submission) and re-attested to every 120 days thereafter. All 26 Disclosure Questions must be answered.
☐	Work History	A current curriculum vitae/resume may be submitted to produce the most recent 5 years of work history (month/year format). This must match the CAQH. Gaps greater than 6 months must be explained in writing.
☐	Professional liability insurance face sheet	The coverage minimums are $1M/$3M with expiration date and provider's name.
☐	National Practitioners Data Bank	If you have knowledge that information pertaining to you has been reported to the National Practitioners Data Bank, an explanation regarding the report must be provided on the CAQH or submit a written statement with the application.
☐	Corporate W-9	With tax ID number (to be consistent with applicant's CAQH and with the Group Participating Provider Agreement (PPA).
☐	Application Fee	Physician Provider - $200 APP Provider - $100
☐	CLIA Certificate	If applicable
☐	Hospital Affiliation	Each Participating Provider (Allied Health Providers and Physicians) **MUST** hold current and unrestricted allied health or medical staff (as applicable) privileges at one or more Mount Carmel Hospitals unless one of the following exceptions applies: ***Indicate which exception applies here:_____.*** **(a)** the Participating Provider does **not** treat his/her patients in the hospital in-patient or hospital outpatient setting; and/or **(b)** the Participating Provider's primary medical practice location is outside of Franklin County, (more than 75% of the Participating Provider's patient contact hours occur at a location(s) outside of Franklin County). Must hold current and unrestricted privileges at a hospital located in the same county as his/her primary medical practice location, unless such Participating Provider does not treat patients in a hospital in-patient, hospital outpatient setting; and/or **(c)** the Participating Provider is a Participating Physician whose specialty is pediatrics or pediatric ophthalmology and he/she is employed by, or contracted through, Partners for Kids.
☐	Cross Coverage Designee	All physicians with or without hospital affiliation must provide a Health Partners cross coverage designee or arrangements for inpatient admissions. **Coverage by a local hospitalist group is acceptable coverage.** Please list the covering physician here: _____ and/or on the CAQH.
☐	APPs	(1) Must be employed by or contracted with MCHS, a Participating Physician or a Participating Physician's medical practice; or (2) if a PA, must provide a valid supervision agreement in place with a Participating Provider; or (3) if an APP, who is a CNP, CNS or CNM, must have a Standard Care Arrangement in place with a collaborating Participating Provider, or (4) if a CRNA, must provide a supervising provider that is a Participating Provider.

Please return credentialing application per Ohio Revised Code (ORC 3963.06(D)) to:

Mail to: Mount Carmel Health Partners
Attn: Justin Wolf (for Physicians) or Cheryl Almendinger (for APPs)
6150 E Broad St
Columbus, OH 43213

Email: healthpartnerscred@mchs.com
Fax: 614-546-4261