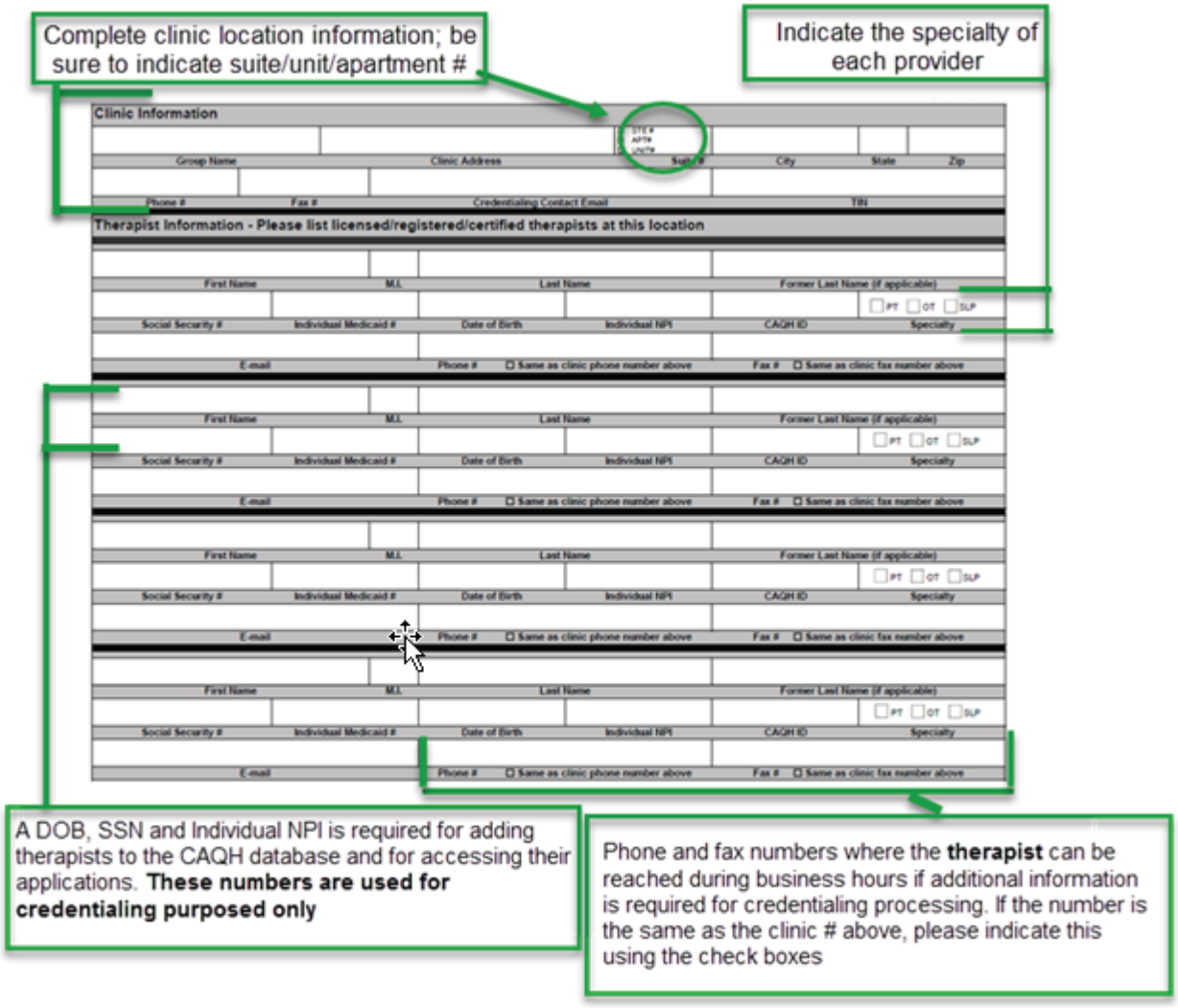
Individual Therapist Credentialing Form

Quick Reference Guide

- Please list therapists at only their primary work location. Fully complete the Individual Therapist Credentialing Form. * Optum does not Credential Assistants.
- Complete at least one form for each clinic location. Each form accommodates information for four therapists.
- Make copies as needed for your clinics and therapists.
- Therapist information is required for credentialing purposes only. Accreditation standards require us to individually credential each therapist.
- Therapists should upload your organization's most recent malpractice declarations page to their CAQH application. The malpractice documentation must state it covers all therapists employed by your organization or contain the names of the therapists.
- Therapists must respond promptly to information requests from OptumHealth.
- When new therapists join your organization, you must contact us to initiate credentialing before they can provide services to our members. Please send this form to optumcred@optum.com or fax 877-309-9421
- For additional questions, please call (800) 873-4575.



Individual Therapist Credentialing Form

OPTUM™

Clinic Information

		☐ STE # ☐ APT# ☐ UNIT#			
Group Name	Clinic Address	Suite #	City	State	Zip

Phone #	Fax #	Credentialing Contact Email	TIN

Therapist Information - Please list licensed/registered/certified therapists at this location

First Name	M.I.	Last Name	Former Last Name (if applicable)

					☐ PT ☐ OT ☐ SLP
Social Security #	Individual Medicaid #	Date of Birth	Individual NPI	CAQH ID	Specialty

E-mail	Phone # ☐ Same as clinic phone number above	Fax # ☐ Same as clinic fax number above

First Name	M.I.	Last Name	Former Last Name (if applicable)

					☐ PT ☐ OT ☐ SLP
Social Security #	Individual Medicaid #	Date of Birth	Individual NPI	CAQH ID	Specialty

E-mail	Phone # ☐ Same as clinic phone number above	Fax # ☐ Same as clinic fax number above

First Name	M.I.	Last Name	Former Last Name (if applicable)

					☐ PT ☐ OT ☐ SLP
Social Security #	Individual Medicaid #	Date of Birth	Individual NPI	CAQH ID	Specialty

E-mail	Phone # ☐ Same as clinic phone number above	Fax # ☐ Same as clinic fax number above

First Name	M.I.	Last Name	Former Last Name (if applicable)

					☐ PT ☐ OT ☐ SLP
Social Security #	Individual Medicaid #	Date of Birth	Individual NPI	CAQH ID	Specialty

E-mail	Phone # ☐ Same as clinic phone number above	Fax # ☐ Same as clinic fax number above