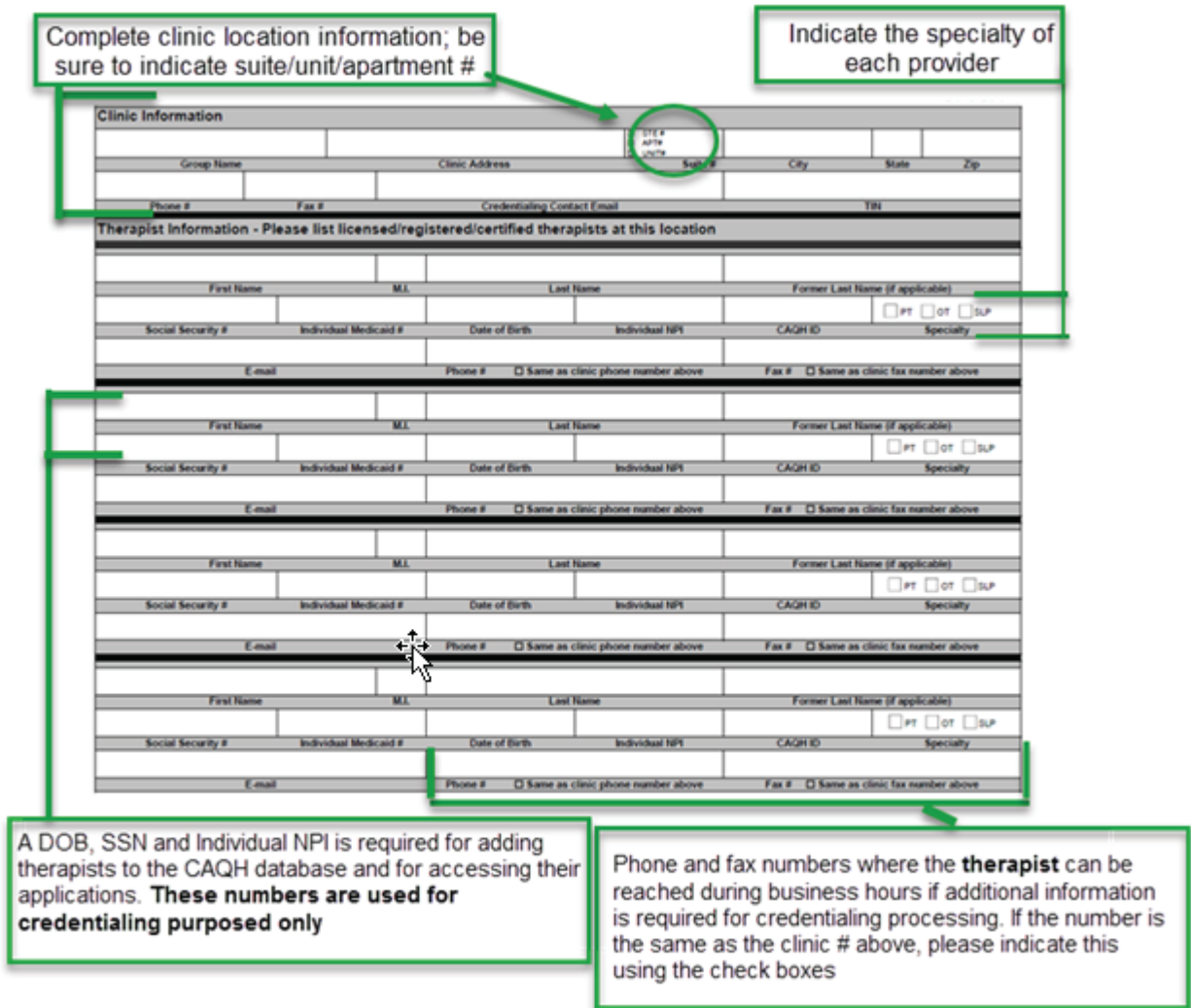


Individual Therapist Credentialing Form

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.



The form is titled "Individual Therapist Credentialing Form" and is divided into two main sections: "Clinic Information" and "Therapist Information".

Clinic Information: This section includes fields for Group Name, Clinic Address, Suite #, City, State, Zip, Phone #, Fax #, Credentiaing Contact Email, and TIN. A callout box points to the Suite # field with the text: "Complete clinic location information; be sure to indicate suite/unit/apartment #".

Therapist Information: This section is repeated for up to four therapists. Each therapist's information includes: First Name, ML, Last Name, Former Last Name (if applicable), Social Security #, Individual Medicaid #, Date of Birth, Individual NPI, CAQH ID, and Specialty. There are checkboxes for PT, OT, and SUP. Below these are fields for Phone # and Fax #, with checkboxes for "Same as clinic phone number above" and "Same as clinic fax number above". A callout box points to the Specialty field with the text: "Indicate the specialty of each provider".

At the bottom of the form, there are two callout boxes:

- One pointing to the Social Security #, Individual Medicaid #, and Individual NPI fields: "A DOB, SSN and Individual NPI is required for adding therapists to the CAQH database and for accessing their applications. **These numbers are used for credentialing purposes only**".
- Another pointing to the Phone # and Fax # fields: "Phone and fax numbers where the **therapist** can be reached during business hours if additional information is required for credentialing processing. If the number is the same as the clinic # above, please indicate this using the check boxes".



Individual Therapist Credentialing Form

Clinic Information

Group Name		<input type="checkbox"/> STE # <input type="checkbox"/> APT# <input type="checkbox"/> UNIT#		City	State	Zip
Phone #	Fax #	Credentiaing 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)
Social Security #	Individual Medicaid #	Date of Birth	Individual NPI
E-mail	Phone #	CAQH ID	Specialty
		<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP	
		<input type="checkbox"/> Same as clinic phone number above <input type="checkbox"/> Same as clinic fax number above	

First Name	M.I.	Last Name	Former Last Name (if applicable)
Social Security #	Individual Medicaid #	Date of Birth	Individual NPI
E-mail	Phone #	CAQH ID	Specialty
		<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP	
		<input type="checkbox"/> Same as clinic phone number above <input type="checkbox"/> Same as clinic fax number above	

First Name	M.I.	Last Name	Former Last Name (if applicable)
Social Security #	Individual Medicaid #	Date of Birth	Individual NPI
E-mail	Phone #	CAQH ID	Specialty
		<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP	
		<input type="checkbox"/> Same as clinic phone number above <input type="checkbox"/> Same as clinic fax number above	

First Name	M.I.	Last Name	Former Last Name (if applicable)
Social Security #	Individual Medicaid #	Date of Birth	Individual NPI
E-mail	Phone #	CAQH ID	Specialty
		<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP	
		<input type="checkbox"/> Same as clinic phone number above <input type="checkbox"/> Same as clinic fax number above	