

**IMPORTANT:**

**PLEASE UTILIZE THIS CHECKLIST TO ASSIST WITH COMPLETING YOUR APPLICATION. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.**

The information requested is required by the Texas Departments of Health and/or Insurance and is based on standards established by any of the following organizations: NCQA (National Committee on Quality Assurance), JCAHO (Joint Commission on Accreditation of Healthcare Organizations), and QARI (Quality Assurance Review Initiative).

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- Texas Standardized Credentialing Application (Revision 01/07)
  - If applicable, explanation of any pending or settled malpractice cases during the last FIVE years (**REQUIRED**);
  - Initialed, Signed and Dated Attestation Pages 11 & 12 (**REQUIRED**);
  - Education (**REQUIRED**) \*Indicate **both** month and year for period attended;
  - Call Coverage (**If Applicable**);
  - Work History (**REQUIRED**) \*Include explanation for gaps of more than six (6) months)
  - Peer References (**REQUIRED**);
  - Letter from Supervising Physician confirming supervision of applicant's responsibilities (**Required for Physician Assistant and Nurse Practitioner and Certified Nurse Midwife.**)
  - Copy of current State license (**REQUIRED**);
  - Copy of current DEA certificate (**REQUIRED**);
  - Copy of current DPS certificate (**REQUIRED**);
  - Current Board Certificate(s) (**REQUIRED**);
  - Current CLIA certificate for each practice location (**A YES or NO answer is REQUIRED. If YES, submit certificate**);
  - Current TDH Radiology (**X-Ray included**) certificate for each practice location (**if applicable**);
  - Current copy of Malpractice Insurance Face Sheet (**REQUIRED**);
  - Current copy of W-9 (**REQUIRED**) \*Must reflect exact "bill pay to";
  - Demographic Information Form (**REQUIRED**) \*Need for El Paso First Provider set-up;
  - Current Curriculum Vitae ((**REQUIRED**) \*Indicate **both** month and year
  - EPSDT/ THSteps Number (**if applicable**);
  - Hospital Privileges (**REQUIRED**) \*If none, provide a letter from the physician who will be admitting on your behalf.
  - NPI – National Provider Identifier (**REQUIRED**)
  - If you are a Medicaid provider, please include copies of the letters from TMHP that provide your TPI numbers and effective dates, both individual and group. (**REQUIRED for participation in Medicaid Plans**)

**NOTE:** AN APPLICATION CANNOT BE PROCESSED IF FIELDS ARE LEFT BLANK; PLEASE USE "N/A" IF NOT APPLICABLE. A "PENDING" RESPONSE IS NOT ACCEPTABLE - ALL LICENSES/CERTIFICATES MUST BE **CURRENT** AND SUBMITTED ALONG WITH THE APPLICATION IN ORDER TO GET PROCESSED.

*Completion of this application does not constitute approval or acceptance of participating status in El Paso First Health Plans, Inc.*