FOUNDATIONAL PROVIDER CREDENTIALING

Provider Intake Form — Credentialing & Claims Setup

Complete all sections below. This information is used to create your CAQH profile, submit insurance applications, set up Availity/Optum, and configure your EHR. All data is handled in compliance with HIPAA. Email completed form to: **info@foundationalprovider.com**

1. PERSONAL INFORMATION

First Name | **Middle Name** | **Last Name** | **Suffix (Jr, III, etc.)**

Date of Birth (MM/DD/YYYY) | **SSN (last 4 for verification)** | **Gender**

Email Address | **Phone Number** | **Alternate Phone**

Home Address | **City** | **State** | **ZIP**

2. PRACTICE INFORMATION

Practice / Business Name | **Entity Type (LLC / PLLC / S-Corp)** | **EIN / Tax ID**

Practice Address | **City** | **State** | **ZIP**

Practice Phone | **Practice Fax** | **Practice Email**

Current EHR (SimplePractice, etc.) | **Currently on a Platform? (Headway, Alma, etc.)** | **Number of Providers**

3. PROFESSIONAL LICENSE

License Type (LPC, LCSW, PsyD, MD, NP, PA, etc.) | **License Number** | **State** | **Expiration Date**

Additional License Type (if any) | **License Number** | **State** | **Expiration**

DEA Registration Number (if applicable) | **DEA Expiration Date** | **DEA State**

4. NPI INFORMATION

Individual NPI (Type 1) | **Group NPI (Type 2) — if applicable** | **CAQH ID (if existing)**

If you don't have an NPI or CAQH, leave blank — we will register them for you.

5. MALPRACTICE INSURANCE

Insurance Carrier Name | **Policy Number** | **Expiration Date**

Coverage Amount (per occurrence / aggregate) | **Claims-Made or Occurrence?**

6. EDUCATION

Highest Degree (MA, MS, PhD, PsyD, MD, DO, DNP, etc.)	Field of Study	Year Graduated	Institution Name
Additional Degree (if any)	Field	Year	Institution

7. WORK HISTORY (most recent 5 years)

List your most recent positions. Payers require 5 years of work history with no gaps longer than 6 months.

		From (MM/YYYY)	To (MM/YYYY)
Position 1: Employer / Practice Name	Title / Role		
Position 2: Employer / Practice Name	Title / Role	From (MM/YYYY)	To (MM/YYYY)
Position 3: Employer / Practice Name	Title / Role	From (MM/YYYY)	To (MM/YYYY)

8. PROFESSIONAL REFERENCES (3 required)

Must be licensed healthcare professionals who have worked with you. Cannot be relatives.

Reference 1: Full Name	Title / License	Phone	Email

Reference 2: Full Name	Title / License	Phone	Email

Reference 3: Full Name	Title / License	Phone	Email

9. HOSPITAL PRIVILEGES (if applicable)

Hospital Name	City, State	Privilege Type	Status (Active/Inactive)

If none, write "N/A". Most behavioral health providers do not have hospital privileges.

10. DISCLOSURE QUESTIONS

1. Have you ever had your professional license revoked, suspended, or restricted in any state? _____ YES _____ NO

2. Have you ever been excluded from participation in Medicare, Medicaid, or any federal/state program? _____ YES _____ NO

3. Have you ever had malpractice claims filed against you? _____ YES _____ NO

4. Have you ever been convicted of a felony? _____ YES _____ NO

5. Have you ever had hospital privileges denied, revoked, or suspended? _____ YES _____ NO

6. Are there any gaps greater than 6 months in your work history? _____ YES _____ NO

If YES to any question, provide a written explanation on a separate page.

11. PLAN SELECTION

Plan	Providers	Monthly	Growth & Ops
Solo Founder	1	$199/mo + $300 deposit	$110/mo
Group Starter	2-6	$349/mo	$249/mo
Group Pro	7-12	$479/mo	$320/mo
Enterprise	13+	Starting at $549/mo	Custom

Selected Plan **Number of Providers to Credential**

12. AUTHORIZATION & SIGNATURE

By signing below, I authorize Foundational Provider Credentialing to: (1) submit credentialing applications to insurance payers on my behalf, (2) create and manage my CAQH ProView profile, (3) submit insurance claims through Availity and/or Optum on my behalf, (4) access and manage my provider enrollment records, and (5) communicate with insurance payers regarding my applications. I certify that all information provided in this form is true and complete. I understand that false information may result in termination of services and denial of credentialing applications. I understand credentialing typically takes 60-180 days per payer and I must be patient during this process.

Print Name **Signature** **Date**