Indiana University Health

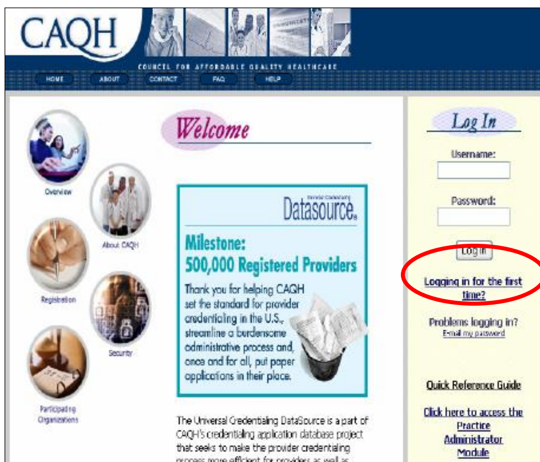
CAQH Application Instructions

We ask that all providers complete the online CAQH application as part of their initial/reappointment applications. To simplify the process, you may want to gather the following documentation prior to beginning:

- Current professional liability insurance policy face sheet
- DEA Registration
- State Controlled Dangerous Substance Certificate (CDS or CSR)
- State License Certificate
- ECFMG Certificate (if applicable)
- BLS/ACLS
- Medicare and Medicaid number (if applicable)
- NPI number
- UPIN and UPIN number (if applicable)
- Board Certification information

Once you have gathered the necessary documentation, use the CAQH link provided on your Practitioner Home Page or navigate to https://upd.caqh.org/oas**.** Follow the steps below to successfully submit your CAQH application and then return to your PHP to complete the necessary supplemental forms.

1. **REGISTRATION:** If this is your first time using CAQH, you must register before beginning your application.



On the Welcome Screen:

Click on LOGGING IN FOR THE FIRST TIME

This will bring up the Getting Started screen which gives an overview of the application along with a summary of requirements for completing the application.

Click on **NEXT** to bring up the Authentication screen.

Authentication

As the system is launched in each state CAQH Provider IDs will be sent to each provider in participating health plans. If you have received a CAQH Provider ID, please enter the following authentication information. After successful authentication, you will be able to generate your own unique password and begin using the system.

CAQH ProviderID (Required):

You will be authenticated if one of the following items matches our records. Please provide as much of the data below as possible.

Social Security Number:

Date of Birth (mmddyyyy):

DEA Number:

UPIN:

License Number:

BACK NEXT

On the Authentication Screen:

Enter your CAQH Provider ID:

Enter your SSN:

Enter your DOB:

These must be entered as they were provided on your request for membership form.

Click on **NEXT** to bring up the Registration screen.

On the Registration Screen:

Enter your registration information. This should include your email information along with the email of the credentialing contact or practice manager that is assisting you with completing your application requirements (if applicable).

Enter a user name and password. Your user name and password must be at least 6 characters and no more than 15 characters in length. Keep your user name/password in a safe place as you will need these to make updates and re-attest in the future.

Click **SUBMIT**

If your registration is successful a log-in screen will display. Enter the user name and password that you created.

Click **LOG IN**

2. **COMPLETE/UPDATE APPLICATION**: Once you have successful logged into the CAQH Universal Provider Datasource, you will begin entering your information following the requirements listed below. If you have to stop or break before you have completed the application, save your work. This may be done by selecting the "Audit" tab, clicking the "Run Audit" tab and then the "Log Out" tab.

From the Start Page/Tab:

If you are new to CAQH or need to update information on an existing application: Click the **COMPLETE/UPDATE Application** bubble.

If you have a CAQH application on file, and all information is current: Click the **Re-Attest** bubble to re-attest for a reappointment application

- **ALL** providers must have a current CAQH on file
- You must Re-Attest as of the date of request. Prior reattestations (regardless of how recent) **WILL NOT** be accepted for reappointments.

On the Preparation Tab:

Use the Prepare Tab to begin the application entry process or to make changes to your provider type, primary practice office state or hospital-based provider information.

1. Select your provider type from the drop-down list.
2. Select your primary practice office state from the drop-down list. (Indiana)
3. Select Yes or No to indicate if you practice only in an inpatient setting.

Click **NEXT** to advance to the **ANSWER** tab and the Personal Information page.

On the Answer Tab:

The first section on the **ANSWER** Tab, **Personal information,** includes basic personal info along with personal addresses. In this section be sure to pay close attention to the help menu along the right hand side of the page. Be as thorough as possible.

As you work through the Answer tab, many pages will include **ADD, DELETE, EDIT, IMPORT** and **UPDATE** buttons. – Use **ADD** to add another occurrence for an item such as other names/aliases or new sections to Answer tab pages. The Add button will bring up an additional window. After entering information, use the **UPDATE** or **CANCEL** button on the window to update/save or cancel information.

Note: Do not use the close window **(X)** button in the top right-hand corner of the window.

Use **EDIT** to edit information within the additional occurrences or sections. – Use **DELETE** to delete an entire occurrence or section of

Use **IMPORT** to bring information entered in the Practice Administrator Module into your application, reducing data entry necessary for some sections. **IMPORT** is only available on the Practice Locations, Hospital Affiliations and Professional Liability Insurance pages. You will only see this button if you are associated with the practice manager.

Click **NEXT** to advance to the next section of the **ANSWER** tab, **Professional IDs**.

Start | Prepare | Answer | Audit | Authorize | Attest | Attachments

CAQH Universal Application

Professional IDs -- Go To Specific Sections --

Medical License

State License Number:

License State: [Select from list]

License Type: None

Do you currently practice in this state? Yes No

License Status: None

Issue Date: (mmddyyyy)

Expiration Date: (mmddyyyy)

Click Add to enter additional Medical License(s). ADD

DEA Registration

Do you have a DEA Registration Certificate? Yes No

Federal DEA Number:

Federal DEA State of Registration (if applicable): None

Issue Date: (mmddyyyy)

Expiration Date: (mmddyyyy)

Click Add to enter additional DEA Registration Certificate(s). ADD

On the Answer Tab:

In the **Professional ID** Section of the **ANSWER** tab you will be asked to provide the following:

- State license number, license type, license status, current practice state, issue date, expiration date. If you do not yet have your license, enter Indiana in the license number and Indiana for the state. You will need to update your CAQH when you receive your licensure.
- DEA registration (if applicable), issue date and expiration
- Controlled Substances Registration (if applicable), issue date and expiration date
- Medicare and Medicaid number
- UPIN and UPIN number (if applicable)
- ECFMG and issue date. (if applicable)
- NPI number (10 digits): You must have an NPI number to complete the application. If you have not yet obtained your NPI, enter 9999999996. You will need to update your CAQH when you receive your NPI

Click **NEXT** to advance to the next section of the **ANSWER** tab, **Education and Personal Training.**

Start | Prepare | Answer | Audit | Authorize | Attest | Attachments

CAQH Universal Application

Education -- Go To Specific Sections --

Professional School

Graduate Type: US/Canadian Graduate; Non-US/Canadian Graduate; Fifth Pathway Graduate

Other Relevant Education

Do you have other relevant education for which a degree was obtained? Yes No

Click Add to enter other relevant degrees (e.g. MBA, MPA, PhD). ADD

BACK | AUDIT | NEXT

Start | Prepare | Answer | Audit | Authorize | Attest | Attachments

CAQH Universal Application

Professional Training -- Go To Specific Sections --

Internship or Residency

State: None

Institution/Hospital Name: [Select from list]

Department:

Institution/Hospital Address:

City:

Province:

On the Answer Tab:

The next two sections of the **ANSWER** tab are the **Education** and **Personal Training** sections.

Education Section:

- Select the Graduate Type
- Add Professional Schooling including address, phone numbers, and degree start and end dates.

Professional Training Section:

Complete all relevant sections within this section:

- Institution's Name, address, phone numbers
- Start/End Dates
- Affiliate University
- Program Director

Use the **ADD** button to enter additional Internships, Residency Programs, and Fellowships. Include **ALL** prior training.

Click **NEXT** to advance to the next section of the **ANSWER** tab, **Specialties**.

Start | Prepare | Answer | Audit | Authorize | Attest | Attachments

CAQH Universal Application

Specialty -- Go To Specific Sections --

Primary Specialty

Primary Specialty:

[Select from list]

Board Certified? Yes No

Do you wish to be listed in the directory under this specialty?

HMO Yes No

PPO Yes No

POS Yes No

Secondary Specialty

Do you have a Secondary Specialty? Yes No

Secondary Specialty:

None

Board Certified? Yes No

Do you wish to be listed in the directory under this specialty?

HMO Yes No

PPO Yes No

POS Yes No

Additional Specialty

Do you have any Additional Specialties? Yes No

Click Add to enter your additional specialties. ADD

Certifications

Do you hold the following certifications? If yes, provide expiration dates. (BLS, ACLS, PALS, ATLS, NALS, ALSO, CPR)

Basic Life Support (BLS) Yes No

Expiration Date:

On the Answer Tab:

The next section of the **ANSWER** tab, the Specialties section, is broken up into several parts:

Primary and Secondary Specialties:

- Select specialty
- Board Certification
- Directory Preferences
- Include Additional Specialties if appropriate

Certifications:

- Basic Life Support (Exp. Date)
- Advanced Cardiac Life Support (Exp. Date)
- Advanced Life Support in OB (Exp. Date)
- Pediatric Advanced Life Support (Exp. Date) Advanced Trauma Life Support (Exp. Date)
- Neonatal Advanced Life Support (Exp. Date)
- Cardio-Pulmonary Resuscitation (Exp. Date)

Additional Interests:

- Provide additional areas of professional practice interest, activities, procedures, diagnoses or populations, ex. HIV/AIDS.

Click **NEXT** to advance to the next section of the **ANSWER** tab, **Credentialing Contact.**

Start | Prepare | Answer | Audit | Authorize | Attest | Attachments

CAQH Universal Application

Credentialing Information -- Go To Specific Sections --

Credentialing Contact

Last Name:

First Name:

Middle Initial:

Address:

City:

State: None

Zip Code:

Phone:

Fax:

Email:

BACK AUDIT NEXT

On the Answer Tab:

The next section of the **ANSWER** tab is **Credentialing Contact**.

Your credentialing contact will be cc'd on **ALL** email updates/requirements sent to the practitioner. It is imperative that the email for this contact be accurate and not a yahoo or AOL account as these are not considered secure.

Click **NEXT** to advance to the next section of the **ANSWER** tab, **Practice Locations**.

CAQH
COUNCIL FOR AFFORDABLE QUALITY HEALTHCARE

Start | Prepare | Answer | Audit | Authorize | Attest | Attachments

CAQH Universal Application

Practice Locations -- Go To Specific Sections --

Practice Details

If you have not already done so, please click the "Edit" button under each practice location to complete the required information. Click Add to enter a practice location that is not already listed below. Click Import to import data that your office staff may have already entered for you.

ADD IMPORT

Physician Group/Practice Name (as it appears on the W9): Doctor Iuhealth Primary Practice
950 North Meridian
Indianapolis, IN 46202

EDIT DELETE COPY PRACTICE

BACK PRACTICE LOCATIONS DONE

On the Answer Tab:

The next section of the **ANSWER** tab is **Practice Locations.**

Use the **ADD** button to enter a new location or use the **IMPORT** button to import practice locations information entered by your practice manager.

Use **COPY** to create an identical copy of the practice you select and list it as an additional practice location. This precludes having to completely re-enter all of the information multiple times.

Providers who indicate that they practice exclusively within the inpatient setting are not required to complete the Practice Locations section.

Click **NEXT** to advance to the next section of the **ANSWER** tab, **Hospital Affiliations**.

Start | Prepare | Answer | Audit | Authorize | Attest | Attachments

CAQH Universal Application

Hospital Affiliations -- Go To Specific Sections --

Do you have hospital privileges? Yes No
If you do not admit patients, what admitting arrangements do you have?

List all hospitals where you currently have privileges.

Primary Hospital IMPORT

State: None
Hospital Name: None
Address:
City:
ZIP Code:
Phone Number:
Fax:
Affiliation Start Date (mm/yyyy):
Affiliation End Date (mm/yyyy):
Department Name:
Department Director's Last Name:
Department Director's First Name:
Department Director's Middle Initial:
Full unrestricted privileges? Yes No
Admitting Privilege Status (e.g. None, Full & Unrestricted, Provisional, Restricted, Temporary): None
Are privileges temporary? Yes No
Of your total annual admissions, what percentage is to this hospital? %
Please explain if you are no longer affiliated with this hospital:

Other Hospitals ADD IMPORT

On the Answer Tab:

The next section of the **ANSWER** tab is **Hospital Affiliations.**

Hospital specific location information may be imported by selecting the **IMPORT** button and hospital name.

List ALL hospitals where you currently hold privileges and include the following detail:

- Hospital Privileges
- Affiliation start/end date
- Admitting arrangements privilege status
- Full/restricted privileges
- Total annual admissions and % of admissions to this hospital
- Department Name/ Director

Use **ADD** or **IMPORT** to include additional hospital affiliations

Click **NEXT** to advance to the next section of the **ANSWER** tab, **Hospital Affiliations**.

Start | Prepare | Answer | Audit | Authorize | Attest | Attachments

CAQH Universal Application

Professional Liability Insurance -- Go To Specific Sections --

Professional Liability Carrier IMPORT

Self-Insured? Yes No

Carrier/Self Insured Name:

[Select from list]

Address:

City:

State: None

Province:

Postal Code:

Country: None

Phone Number:

Policy Number:

Original Effective Date (mmyyyy):

Current Effective Date (mmyyyy):

Current Expiration Date (mmyyyy):

Do you have unlimited coverage with this insurance carrier? Yes No

Amount of coverage per occurrence:

Amount of coverage aggregate:

Does this policy include tail coverage? Yes No

Individual Coverage: Yes No

Other Professional Liability Carrier(s)

Click Add to enter other current, future, or secondary Professional Liability Carrier(s). Enter previous Professional Liability Carrier(s) if you have been with your current carrier(s) for less than ten (10) years. NOTE: A longer period may be required by your healthcare entity. ADD IMPORT

On the Answer Tab:

The next section of the **ANSWER** tab is **Professional Liability Insurance**

Enter Current Professional Liability information: If you have not updated you Liability insurance enter your current policy/student policy so that you can continue through the application. You will need to update the CAQH as soon as you have obtained insurance or your application will not be considered complete.

Include the following detail:

- Carrier/Self Insured name
- Policy #
- Original/Current effective dates
- Current Exp. Date
- Individual/Tail/Unlimited coverage
- Amount of occurrence/aggregate coverage

Click **ADD** to enter other current, future, or secondary Professional Liability Carrier(s). Enter previous Professional Liability Carrier(s) if you have been with your current carrier(s) for less than ten (10) years.

Click **NEXT** to advance to the next section of the

Start | Prepare | Answer | Audit | Authorize | Attest | Attachments

CAQH Universal Application

Work History -- Go To Specific Sections --

Enter both your Current and your Prior Work History for the past 10 years.

Please provide 10 years of work history, if applicable. In addition, please explain any time gaps greater than 3 months. This information must be complete; otherwise, a health plan may need to contact you for additional information and you may experience a delay in the processing of your credentialing application.

Note: Some organizations may require a full work history beginning with your professional degree and the reporting of all gaps in work history. Check with your credentialing organization.

Current Work Information

Practice/Employer Name:

Address:

City:

State: None

Province:

Postal Code:

Country: None

Phone:

Fax:

Start Date (mmyyyy):

Current Employer? Y/N: Yes No

Leave End Date blank to indicate employed at time of attestation. The word "PRESENT" will print on the application in the End Date.

End Date (mmyyyy):
Leave End Date blank to indicate "Present". (e.g., currently enrolled, current employer, etc.)

Reason for departure:

On the Answer Tab:

The next section of the **ANSWER** tab is **Work History**

Enter both your current and prior work history beginning with the most recent. Provide **10 years** of work history, if applicable. In addition, please explain any time gaps greater than 3 months. This information must be **complete**; otherwise, a health plan may need to contact you for additional information and you may experience a delay in the processing of your credentialing application.

Include the following detail:

- Practice/Employer name, address, contact
- Reason for departure
- Current active or reserve military
- Work history gaps greater than 3 months including explanation.

Click **ADD** to additional work information

Click **NEXT** to advance to the next section of the **ANSWER** tab, **Professional References**.

Start | Prepare | Answer | Audit | Authorize | Attest | Attachments

CAQH Universal Application

Professional References -- Go To Specific Sections --

Professional References

Please provide three professional references that are not colleagues in your own group practice and are not relatives.

Reference #1

Last Name:

First Name:

Provider Type: None

Address:

City:

State: None

Province:

Postal Code:

Phone:

Fax:

Country: None

Reference #2

Last Name:

First Name:

Provider Type: None

Address:

City:

State: None

Province:

Postal Code:

On the Answer Tab:

The next section of the **ANSWER** tab is **Professional References**

Provide three professional references that are not colleagues in your own group practice and are not relatives.

References listed should be personally acquainted with applicant's professional and clinical performance, competence, and ability to perform the privileges requested.

Include:

- In Reference #1 Enter your Department Chair or Program Director
  (If applicant out of training for less than 5 years)
- Initial Applicants MUST include at least one reference from applicant's immediate past affiliation

Mid-level providers (CRNAs, NPs, CNS) must include the Supervising/Collaborating Physician

Click **NEXT** to advance to the next section of the **ANSWER** tab, **Disclosure**.

Start | Prepare | Answer | Audit | Authorize | Attest | Attachments

CAQH Universal Application

Disclosure -- Go To Specific Sections --

Licensure

1. Has your license, registration or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board? Yes No
   If Yes, please provide an explanation below.
2. Has there been any challenge to your licensure, registration or certification? Yes No
   If Yes, please provide an explanation below.

Hospital Privileges and Other Affiliations

3. Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? Yes No
   If Yes, please provide an explanation below.
4. Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? Yes No
   If Yes, please provide an explanation below.
5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? Yes No
   If Yes, please provide an explanation below.

On the Answer Tab:

The final section of the **ANSWER** tab is the **Disclosure**

This section includes questions regarding:

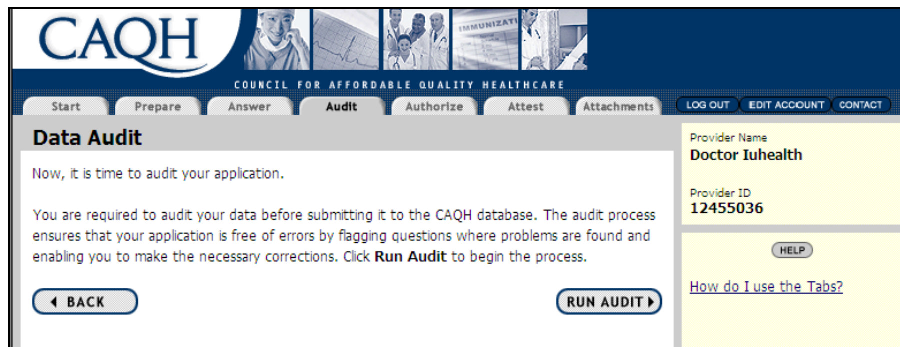
- Licensure
- Hospital Privileges
- Educations, Training and Board Certification
- DEA or CDS
- Medicare/Medicaid. Other Governmental Programs
- Sanctions and Investigations
- Professional Liability Insurance and Claims
- Malpractice Claims
- Criminal and Civil History
- Ability to Perform Job

This section must be complete and accurate.

An answer of **YES** to **ANY** disclosure question will require a full written explanation.

Click **NEXT** to advance to the **AUDIT** tab.

3. When application has been completed, run an audit by clicking on the “Audit” tab and selecting “Run Audit”. Any “Required Fixes” must be corrected before you can move forward. You may disregard any “Suggested Fixes” that may be identified.



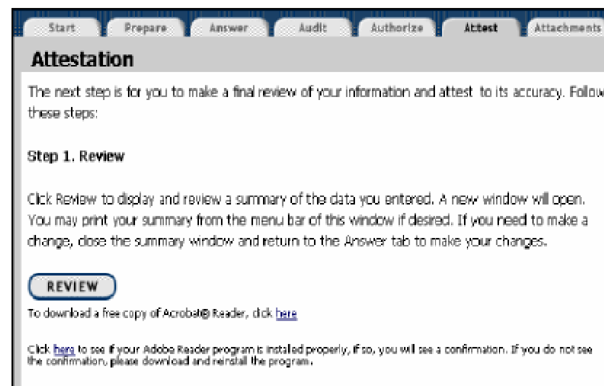
4. Once the “Required Fixes” have been made, click “Next” which will take you to the **Healthcare Organization Authorization** section. Click on the button to grant access to your information to **ALL** CAQH healthcare organizations. Then click “Save” and “Next”.

To ALL of the healthcare organizations listed above AND to any healthcare organization that in the future represents to CAQH either that I am a participating provider or that I am in the process of being credentialed as a participating provider.

OR

To only the healthcare organizations I indicate below...

5. You are now in the **Attestation** section of the application. Click “Review and a completed file of your information will display. Please review and, if necessary, go back and make any changes. When all is accurate, click “Review Complete”. This brings up the attest button. Read the attestation statement and, if you are in agreement, click the “Attest” tab.



6. You are now in the **Attachments** section of the application. For providers with historical information in CAQH: please remove attachments that are no longer valid. This will assist the Credentialing Office and speed up the application process.

7. Print the Authorization, Attestation and Release Form and the Fax Cover Sheet/ Email Coversheet. Sign and date the authorization form.

8. Complete the fax cover sheet and fax it, with copies of the applicable supporting documents, to include the authorization form, to CAQH at: 866-293-0414. **OR** Sign, Date, and Scan the form. Create an email to **Supportingdocsupd@acsgs.com** and attach the AAR Form, email cover sheet, and supporting documents. Include your CAQH Provider ID, full name and the documents you are sending in the body of the email.