INSTRUCTIONS:
COMPLETING THE SUTS CLINICIAN CREDENTIALING FORM

- The SUTS Clinician Credentialing form must be completed by all clinicians providing direct services to SUTS beneficiaries. The SUTS Clinician Credentialing form must be completed IN ADDITION to the UniCare request form.
- **New users** should send both UniCare request and Clinician Credentialing forms to the email shown below.
- Only the Clinician Credentialing form is required for updates, expirations, or leave of absences.

Please **READ ALL INSTRUCTIONS** before filling out this form.

This is a fillable Adobe Acrobat PDF form. Please use the ***free*** Adobe Acrobat Reader software to fill in the fields. If you do not have Adobe Acrobat, download it from here: https://get.adobe.com/reader/

1. The PDF version of Clinician Credentialing form should be downloaded from the email and saved to the desktop before the form can be completed.
2. The Clinician Credentialing form can also be downloaded from the BHSD website: https://www.sccgov.org/sites/bhd-p/EHR/unicare/Documents/SUTS_1501_vAA_Clinician_Credentialing_Form_11384586.pdf
3. ***ALL APPLICABLE FIELDS MUST BE FILLED OUT***.
4. The Clinician Credentialing form should be reviewed for accuracy and completeness before submission to avoid delays in processing.
5. The completed Clinician Credentialing form should be **saved to the desktop** before it is emailed to the sutscredential mailbox.
6. **The email with attachment(s) should be sent to the SUTS mailbox,** sutscredential@hhs.sccgov.org
   Before sending the email to above mailbox, **please make sure applicable attachments are attached to the email.**

8. The sender will receive an email confirmation of the submission.

If a clinician works for multiple agencies, a separate Clinician Credential form must be completed for each agency (one per agency).

How to enter each field in the Clinician Credentialing form

1) 1 ○ New ○ Update ○ Removal

Please check one:
New: The **New** option should be checked for all new counselors in an agency. If you are a new clinician, please also attach the UniCare request forms.
Update: The **Update** option should be used when you have renewed a credential, moved location (**L-CODE**) within the agency or changed the number of hours worked at each location.
Removal: **The Removal option *must be filled out when a clinician leaves the agency.***

2 ○ Temporary Absence — Absence Start Date: __ __ . __ __ . __ __ (Y Y . M M . D D) — Absence Return Date: __ __ . __ __ . __ __ (Y Y . M M . D D)

Extended temporary absences must be reported to SUTS. Please enter the absence start and return dates for absences longer than **2 weeks.**

3) **Provider's (Clinician's) Last Name:** Your last name (as stated on your credential and with the board). If your name is longer than the space provided, fill out as much of your name that fits the space. Write your full name in the comment section.
4) **Provider's (Clinician's) First Name:** Your first name (as stated on your credential and with the board). If your name is longer than the space provided, fill out as much of your name that fits the space. Write your full name in the comment section.
5) **Provider's (Clinician's) Middle Name:** Your middle name (as stated on your credential)
6) **Hire date**: The date you were hired at the AGENCY (YY.MM.DD)
7) **Manager's Last Name**: Your Managers last name
8) **Manager's First Name**: Your Managers first name
9) **DEA number:** Enter your DEA number, if applicable
10) **UniCare Provider Code:** Enter your UniCare provider, if applicable
11) **NPI Number - Type 1 (Clinician):** NPI number. Note: RNs and LVNs need not enter an NPI number.
12) **Taxonomy Code:** your taxonomy. Note: RNs and LVNs need not enter an NPI number.
13) **Taxonomy/NPI enumeration date:** (YY.MM.DD**)**

NOTE: 11-13 can be found NPPES NPI Registry

NPI	Taxonomy
Enumeration Date	

14) **Provider's (Clinician's) Email:** Your work email address
15) **California Professional Certification Number**: Your License number
16) **Professional Cert. Effective Date:** Date your credential/license was issued (YY.MM.DD)
17) **Professional Cert. Expiration Date:** Date your credential/license expires (YY.MM.DD)

An example is shown in the screen shot on the next page.

Certemy®

CCAPP
The registry

Type to search

ALL A B C D E F G H I J K L M N O P Q R S T U V W X Y Z Displayed 1-20 of 100128

Name	Ethics Status	Expiration Status	Credential ID	Credential acronym	Valid From	Valid To	Original issue date

LICENSE NUMBER **LICENSE TYPE:** ASSOCIATE MARRIAGE & FAMILY THERAPIST
LICENSE STATUS: LICENSE RENEWED & CURRENT **EXPIRATION DATE**
SECONDARY STATUS: N/A
CITY: SAN JOSE **STATE:** CALIFORNIA **COUNTY:** SANTA CLARA **ZIP**

18) **Mark the license you have**: Mark the license that applies to you
19) **List any board certification, special training, experience or specialization:**
20) **List any cultural capabilities (i.e. TAY, Veterans, etc.):**
21) **Language Capacity:** Please mark all languages you are fluent in, **Including ENGLISH**. If you are fluent only in English, mark English.
22) **Other Lang 1-3**: If you are fluent in a language other than above listed thresh hold languages, enter up to 3 languages.
23) **Cultural Competency Training (hrs):** The number of CC training hours you have had in the last 24 months, if you are new and have ***not*** had this training yet, please mark 0.
24) **Telehealth Provider:** Please mark 'Yes' or 'No'. If you have checked yes, you must attach a training certificate with this form if available.
25) **Have you ever had any suspension or curtailment of hospital or clinic privileges:** Please mark 'Yes' or 'No'. If yes, please attach a list.
26) **Have you ever had any liability claims filed against you:** Please mark 'Yes' or 'No'. If yes, please attach a list.
27) **Have you ever had any sanctions from participating in Medicare/Medicaid/Medi-Cal**: Please mark 'Yes' or 'No'. If yes, please attach a list.
28) **Have you ever had any sanctions, limitations or revocation on your license by state agency or licensing board:** Please mark 'Yes' or 'No'. If yes, please attach a list.

29 & 30) Organization Name: Please select the appropriate agency.

31) **L code 1:** Agency's location code, not to be mistaken for your U-code. **Start Date** (yy.mm.dd), **End Date** (yy.mm.dd), **Full time equivalent** fill in the # of hours your work each week

32-34, are only required if you work at multiple locations with this agency

35) Exit date: Date you left the agency (YY.MM.DD), if applicable.
36) Comments: Any additional comments you may offer

- **Attestation**:

37) Enter your name in lieu of your signature: Your name serves as a signature to the attestation of this form.
38) Date: (YY.MM.DD) the date you are signing the form. ***Please make sure when you are updating that you have the correct date marked.***