INSTRUCTIONS FOR FILLING OUT THE **CLINICIAN CREDENTIALING FORM**

- The Clinician Credentialing form must be completed by all clinicians providing direct services IN ADDITION to the UniCare request form.
- New users should sent both UniCare request and Clinician Credentialing forms to the email shown below.
- Only the Clinician Credentialing form is required for updates and expirations.

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 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 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 completion before submission to avoid delays in processing.

5. The completed Clinician Credentialing form should be saved to the desktop before sending.

6. Clicking the "Email" button on the top of the Clinician Credentialing form will automatically direct the sender to the sutscredential@hhs.sccgov.org., A window with a new email message will open. Email address and attachment will be automatically populated. If Adobe does not recognize an agency's email system, it may be necessary to manually attach the form into the email.
7. **The email with attachment should be sent to the SUTS mailbox, shown above**. 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 you work at multiple agencies, fill out 1 form **per** agency*.

INSTRUCTIONS FOR COMPLETING THE FORM

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1) **New, Update or Removal**: Check the box
2) **Provider's (Clinician's) Last Name:** Your last name (as stated on your credential)
3) **Provider's (Clinician's) First Name:** Your first name (as stated on your credential)
4) **Provider's (Clinician's) Middle Name:** Your middle name (as stated on your credential)
5) **Hire date**: The date you were hired at the AGENCY (YYYY.MM.DD)
6) **DEA number:** Enter your DEA number, if applicable
7) **UniCare Provider Code:** Enter your UniCare provider, if applicable
8) **NPI Number - Type 1 (Clinician):** NPI number
9) **Taxonomy Code:** your taxonomy
10) **Taxonomy/NPI enumeration date:** (YYYY.MM.DD**)**
11) **Provider's (Clinician's) Email:** Your work email address
12) **California Professional Certification Number**: Your credential/license number
13) **Professional Cert. Effective Date:** Date your credential/license was issued (YYYY.MM.DD)
14) **Professional Cert. Expiration Date:** Date your credential/license expires (YYYY.MM.DD)
15) **Mark the license you have**: Mark what applies to you
16) **List any board certification, special training, experience or specialization:**
17) **List any cultural capabilities (i.e. TAY, Veterans, etc.):**
18) **Language Capacity:** Please mark all languages you are fluent in
19) **Cultural Competency Training (hrs):**The number of CC training hours you have had, if you are new and have ***not*** had this training yet, please leave blank
20) **Telehealth Provider:** Please mark 'Yes' or 'No'. If you have checked yes, you must attach your certificate to your email along with this form.
21) **Have you ever had any suspension or curtailment of hospital or clinic privileges:** Please mark 'Yes' or 'No'. If yes, please attach a list.
22) **Have you ever had any liability claims filed against you:** Please mark 'Yes' or 'No'. If yes, please attach a list.
23) **Have you ever had any sanctions from participating in Medicare/Medicaid/Medi-Cal:** Please mark 'Yes' or 'No'. If yes, please attach a list.
24) **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.
25) **Organization Name**: The Agency you work for
26) **L code 1:** Agency's location code
27) **Full Time Equivalent (Enter the number of hours per week available for DMC Services):** Number of **DMC** service hours available at the location.
28) **Full Time Equivalent (Enter the # of hrs/week):** The number of **total** hours available at this location.

29-37*, are only required if you work at multiple locations with this agency*

38) **Exit date**: Date you left the agency (YYYY.MM.DD), if applicable.
39) **Comments**: Any additional comments you may offer

- **Attestation**:

40) **Enter your name in lieu of your signature**: Fill in your name as a way of signing and attesting to this form
41) **Date:** (YYYY.MM.DD) the date you are signing the form