

Individual Therapist Credentialing Form

Quick Reference Guide

- Please list therapists at only their primary work location. Fully complete the Individual Therapist Credentialing Form. *Optum does not credential Assistants.
- Complete at least one form for each clinic location. Each form accommodates information for four therapists.
- Make copies as needed for your clinics and therapists.
- Therapist information is required for credentialing purposes only. Accreditation standards require us to individually credential each therapist.
- Therapists should upload your organization's most recent malpractice declarations page to their CAQH application. The malpractice documentation must state it covers all therapists employed by your organization or contain the names of the therapists.
- Therapists must respond promptly to information requests from OptumHealth.
- When new therapists join your organization, you must contact us to initiate credentialing before they can provide services to our members. Please send this form to optumcred@optum.com or fax 877-309-9421
- For additional questions, please call (800) 873-4575.

Complete clinic location information; be sure to indicate suite/unit/apartment #

Indicate the specialty of each provider

Clinic Information						
Group Name	Clinic Address	SUITE # APT# UNIT#	Suite	City	State	Zip
Phone #	Fax #	Credentialing Contact Email		TIN		
Therapist Information - Please list licensed/registered/certified therapists at this location						
First Name	M.I.	Last Name	Former Last Name (if applicable)			
Social Security #	Individual Medicaid #	Date of Birth	Individual NPI	CAQH ID	Specialty <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP	
E-mail	Phone #	<input type="checkbox"/> Same as clinic phone number above		Fax #	<input type="checkbox"/> Same as clinic fax number above	
First Name	M.I.	Last Name	Former Last Name (if applicable)			
Social Security #	Individual Medicaid #	Date of Birth	Individual NPI	CAQH ID	Specialty <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP	
E-mail	Phone #	<input type="checkbox"/> Same as clinic phone number above		Fax #	<input type="checkbox"/> Same as clinic fax number above	
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First Name	M.I.	Last Name	Former Last Name (if applicable)			
Social Security #	Individual Medicaid #	Date of Birth	Individual NPI	CAQH ID	Specialty <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP	
E-mail	Phone #	<input type="checkbox"/> Same as clinic phone number above		Fax #	<input type="checkbox"/> Same as clinic fax number above	

A DOB, SSN and Individual NPI is required for adding therapists to the CAQH database and for accessing their applications. **These numbers are used for credentialing purposes only**

Phone and fax numbers where the **therapist** can be reached during business hours if additional information is required for credentialing processing. If the number is the same as the clinic # above, please indicate this using the check boxes

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Clinic Information										
						<input type="checkbox"/> STE # <input type="checkbox"/> APT# <input type="checkbox"/> UNIT#				
Group Name		Clinic Address			Suite #	City		State	Zip	
Phone #		Fax #		Credentialing Contact Email			TIN			
Therapist Information - Please list licensed/registered/certified therapists at this location										
First Name		M.I.	Last Name			Former Last Name (if applicable)				
								<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP		
Social Security #		Individual Medicaid #		Date of Birth		Individual NPI		CAQH ID		Specialty
E-mail			Phone #		<input type="checkbox"/> Same as clinic phone number above			Fax #		<input type="checkbox"/> Same as clinic fax number above
First Name		M.I.	Last Name			Former Last Name (if applicable)				
								<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP		
Social Security #		Individual Medicaid #		Date of Birth		Individual NPI		CAQH ID		Specialty
E-mail			Phone #		<input type="checkbox"/> Same as clinic phone number above			Fax #		<input type="checkbox"/> Same as clinic fax number above
First Name		M.I.	Last Name			Former Last Name (if applicable)				
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Social Security #		Individual Medicaid #		Date of Birth		Individual NPI		CAQH ID		Specialty
E-mail			Phone #		<input type="checkbox"/> Same as clinic phone number above			Fax #		<input type="checkbox"/> Same as clinic fax number above