Quality First medical billing

ENROLLMENT SUPPORTING DOCUMENTATION

Provider: ____

Provider demographic Information

- Provider full name
- Home address
- Practice location (s) with address
- Social Security Number
- Date of Birth
- Individual NPI

Education history

- Medical School Name, Address, graduation date, and dates of attendance
- Residency information, Name, Address, dates of attendance

Group / Practice Ownership

- Pay-to address
- Group NPI, if applicable
- Ownership history, if applicable
- Partner information, if applicable
- Current Certificate of Insurance

Licensing information

- Copy of state medical license
- Copy of DEA license, if applicable
- Copy of control substance, if applicable
- Copy of Board of Certification certificate, if applicable
- Copy of current CLIA and/or FDA certification
- Copy of certifying body certificate (i.e. JCAHO), if applicable

Adverse Legal History

- Copy of final adverse legal action documentation and resolution.

Current insurance participation status

- CAQH login
- PECOS login

Electronic Payment Set up

- Written confirmation from the IRS confirming Tax ID with legal business name (example: IRS form CP 575)
- Copy of voided check and/or signed Bank letter on Bank letterhead confirming routing number and account number.

Any questions, please contact Provider Enrollment Services at 866-335-1330
Email: info@q1stmdb.com