AMS Solutions
A SUPERIOR MEDICAL BILLING SERVICE

Opening a New Medical Practice?

Your credentialing & payer enrollment timeline

Brad Becker, CRCR | Regional Billing Manager, AMS Solutions

NEW PRACTICE LAUNCH GUIDE

STARTS AFTER YOUR ENTITY IS FORMED

2026 EDITION

You formed the business. You have the vision. Maybe you already have a location, an EHR, a provider start date and a target opening month.

How do we actually get this practice ready to bill insurance?

A practice can have providers ready to see patients, a beautiful office, staff, equipment, marketing and patients asking for appointments - and still struggle to generate insurance revenue because payer enrollment is incomplete.

THE REAL GOAL

Credentialing a new practice is not about submitting the largest possible stack of applications. It is about building the payer infrastructure the practice actually needs before patients begin walking through the door.

FIRST, DRAW THE BOUNDARY

Where This Guide Begins

AMS STARTS AFTER THE LEGAL ENTITY EXISTS

AMS Solutions does not form LLCs, corporations or other legal entities, and this guide is not legal or tax advice. Your attorney, accountant or other appropriate professional should establish the business structure first.

Once the entity has been formed, the credentialing and revenue-cycle infrastructure can begin taking shape. Before payer enrollment, the practice should generally have access to the core organizational information that applications will require:

- Legal business name
- Tax identification number
- Ownership information
- Business address and contact information
- Banking information
- Organizational documents when required

Do not wait until the office opens

Credentialing is one of the easiest launch tasks to start too late. Payer enrollment may involve NPI registration, Medicare, Medicaid, commercial credentialing, contracting, group affiliations, effective-date confirmation, EFT, ERA, clearinghouse configuration and payer-specific EDI enrollment.

PLANNING RULE

There is no universal credentialing timeline that applies to every payer, specialty and state. Work backward from the intended opening date and begin as early as reasonably possible.

MAKE THE ORGANIZATION ENROLLABLE

Phase 1: Build the Practice Foundation

1

Obtain the Organizational NPI

Healthcare organizations such as physician groups generally use a Type 2 NPI. Individual clinicians generally use Type 1 NPIs. An NPI identifies the provider or organization, but it does not itself credential the practice, enroll it with Medicare or another health plan, or guarantee payment.

2

Make the Tax Information Consistent

Have the legal business name, TIN, W-9 and addresses ready. Small inconsistencies between NPPES, payer applications, banking records and tax information can create unnecessary delays.

3

Lock Down the Practice Location

Know the physical service address, mailing address, billing address, phone, fax, hours, credentialing contact and billing contact. If the location is still changing, identify which applications can move and which must wait.

4

Prepare Banking Early

The practice needs an account capable of receiving payer deposits. Medicare EFT enrollment and many commercial payment setups require banking information and supporting documentation. Do not leave payment infrastructure until the end.

THE FOUNDATION TEST

Can the practice consistently state its legal name, TIN, group NPI, location, ownership and banking information everywhere it will be used? If not, fix that before multiplying inconsistencies across payer applications.

BUILD COMPLETE FILES BEFORE PAYER WORK

Phase 2: Get the Providers Ready

For each provider, confirm the information and documents that will be reused across multiple applications.

• Individual NPI	• Education and training
• Professional license	• Board certification
• DEA registration when applicable	• Work history
• Malpractice coverage	• Hospital affiliations when relevant
• Specialty and taxonomy	• CV and supporting documents
• Medicare status	• CAQH access
• Medicaid status	• Practice location and start date

CAQH should be ready early

For many commercial health plans, CAQH is a core credentialing data source. Review the provider profile before applications begin rather than discovering gaps after multiple payers are already waiting on the same information.

REVIEW	CONFIRM
Demographics, locations, licenses, malpractice, education, work history, board information and hospital affiliations.	Supporting documents, authorization settings and attestation status are current and usable.

BUILD IT ONCE

A complete provider file makes every downstream application easier. A weak file multiplies the same missing-information problem across every payer.

RESEARCH FIRST. CREDENTIAL SECOND.

Phase 3: Stop Before You Apply to Everybody

A new practice does not necessarily need to credential with every insurance company it can find.

MORE PAYER CONTRACTS	**DO NOT AUTOMATICALLY MEAN**	**MORE GOOD BUSINESS**

Every additional payer can mean another application, contract, fee schedule, portal, set of rules, credentialing-maintenance cycle and source of claim complexity.

CREDENTIALING IS A BUSINESS DECISION

Before asking "Which payers can we join?" ask "Which payers does this practice actually need?"

Imagine immediately credentialing with fifteen commercial plans. Six months later, two produce most of the volume, three are occasional, five barely appear, one reimburses poorly and another consumes disproportionate staff time. You did not build a payer strategy. You collected contracts.

The goal is not the most payer logos. The goal is the right network for the practice you are building.

KNOW WHO YOUR PATIENTS ACTUALLY CARRY

Research the Market Before Building the Payer List

LOCAL MARKET

Which insurers and products are common in the city, county and service area? Healthcare markets can change dramatically across surprisingly short distances.

TARGET PATIENTS

Age, specialty, geography, income characteristics, referral patterns and expected Medicare or Medicaid population should shape the payer strategy.

MAJOR EMPLOYERS

Hospitals, school districts, municipalities, universities and large employers can influence which commercial plans show up repeatedly.

COMPETITORS

Review payer participation among comparable local practices. Do not copy them blindly. Use the pattern as evidence and ask why.

REFERRAL NETWORK

Referral-dependent specialties should understand which networks matter to hospitals, PCPs and other sources of patient volume.

PUBLIC DATA

CMS publishes Medicaid managed-care and Medicare Advantage enrollment data that can help show which plans actually cover meaningful populations in a market.

EVIDENCE BEATS BRAND RECOGNITION

Do not credential with a plan simply because the logo is familiar. Credential because the payer matters to your patients, your referral network or your business strategy.

DO NOT TREAT EVERY APPLICATION EQUALLY

Build a Payer Priority List

TIER 1 - MUST HAVE

Core launch payers. Examples may include Medicare, Medicaid, dominant commercial plans, important managed-care products or plans critical to major referral sources.

TIER 2 - STRATEGIC

Payers with meaningful potential value that are worth pursuing, but are not essential to opening day.

TIER 3 - REVISIT LATER

Plans with limited expected volume, weak strategic value, questionable reimbursement or high administrative burden. Reconsider them once real practice data exists.

YOU DO NOT NEED EVERY PAYER BEFORE DAY ONE

Build the right network first. Expand intelligently once the practice has actual patient, referral and revenue data.

Simple payer decision matrix

Factor	Question	Rating
Market presence	How common is the plan among target patients?	Low / Med / High
Expected volume	How many patients are realistically likely to carry it?	Low / Med / High
Reimbursement	Does the economics make sense?	Weak / Acceptable / Strong
Referral importance	Do key referral sources need this network?	Low / Med / High
Admin burden	How difficult is the payer to manage?	Low / Med / High
Network access	Is the network accepting providers in the specialty/area?	Closed / Limited / Open
Strategic value	Does participation accomplish something important?	Low / Med / High

MEDICARE, MEDICAID AND COMMERCIAL PLANS

Phases 4-6: Enroll With the Payers That Matter

4

Medicare

If Medicare matters to the target population, address it early. PECOS is CMS's online Medicare enrollment management system. New practices may need the organization enrolled, individual practitioners enrolled and appropriate reassignment relationships established. Confirm locations, supporting documents, EFT and effective dates.

MEDICARE QUESTION

Do not stop at "Do our providers have Medicare?" Ask: Can Medicare correctly process and pay claims for these providers through this organization?

5

Medicaid

Medicaid is state-specific. Depending on the state, the process may involve state Medicaid enrollment, group affiliation, managed-care plans, provider-specific actions and location setup. Research which managed-care plans actually have meaningful enrollment in the service area before applying everywhere.

6

Commercial Plans

Once the priority list is built, begin payer-specific applications. Requirements vary widely: CAQH, provider or group applications, rosters, ownership data, tax forms, contracting documents, provider-add forms and location information may all be part of the process. Some networks may also be closed or limited.

PRIORITY OVER VOLUME

Tier 1 applications should receive the first attention and the tightest follow-up. Credentialing effort should follow business priority.

AND SUBMISSION IS NOT COMPLETION

Credentialing Is Not the Same as Contracting

CREDENTIALING	CONTRACTING
Primarily verifies that the provider meets the payer's professional qualification requirements.	Establishes network participation terms such as products, locations, effective dates, reimbursement and other contractual requirements.

A payer may approve the provider from a credentialing perspective while the commercial relationship is still incomplete. Confirm the entire pathway before treating the plan as launch-ready.

Track everything

New-practice credentialing becomes chaotic quickly because several applications move at once. A master tracker should show more than a column that says "Pending."

☐ Payer	☐ Provider
☐ Application type	☐ Submission date
☐ Confirmation/reference number	☐ Current status
☐ Missing information	☐ Last follow-up
☐ Next follow-up	☐ Contract status
☐ Effective date	☐ Group affiliation
☐ EFT status	☐ ERA status
☐ EDI status	☐ Billing-ready status

"PENDING" NEEDS CONTEXT

Pending since when? Is the file complete? Has the payer requested anything? When was the last follow-up? What is the next action? Who owns it? Good reporting tells leadership what is happening.

PROTECT BOTH BOOKENDS

Phase 7: Build the Billing Infrastructure

Credentialing is only one part of opening the revenue cycle. The practice also needs to be able to send claims and receive payments. Those are the two bookends.

EHR / PM	CLEARINGHOUSE
Configure providers, locations, payers, fee schedules and billing information correctly.	Confirm the route between the billing system and the payers, including payer IDs and enrollment requirements.

EDI	EFT
Certain payers require electronic claim enrollment or other transaction setup. Do not discover that after weeks of claims are queued.	Set up electronic deposits so payer payments can reach the practice bank account efficiently.

ERA	BILLING WORKFLOW
Configure electronic remittance so adjudication and adjustment information can reach the billing system and support posting/reconciliation.	Define who submits claims, works rejections and denials, posts payments, manages A/R and reports performance from day one.

CAN WE SEND A CLEAN CLAIM?

AND

CAN WE RECEIVE AND POST THE PAYMENT?

DO NOT TRAP PAYER STATUS IN A SPREADSHEET

Phase 8: Connect Credentialing to Scheduling

The front desk and scheduling team need to know which plans are active, pending or intentionally not being pursued, and which providers are ready with each payer. Otherwise patients may be scheduled based on assumptions that are not financially accurate.

SHOULD WE HOLD CLAIMS?

Sometimes. But holding claims should not be the default without understanding payer rules, effective dates, timely filing, retrospective enrollment policies, provider status and contract requirements.

If claims are being held, leadership should know:

☐ Which claims are being held?	☐ For which payer and provider?
☐ Why are they being held?	☐ What effective date is expected?
☐ What is the filing deadline?	☐ Who is monitoring the claims?

What does "ready to open" mean?

- Which payers are active?
- Which payers are pending?
- Which are intentionally deferred?
- Which providers are effective with each payer?
- Can claims be submitted?
- Can payments be received?
- Is ERA configured?
- What claims, if any, will be held?
- Who owns billing?
- Who owns unresolved credentialing?

USE THIS AS A FRAMEWORK, NOT A PROMISE

A Practical New-Practice Timeline

AS SOON AS ENTITY IS READY

Organizational NPI, provider files, CAQH review, demographics, banking preparation and payer market research.

EARLY CREDENTIALING

Medicare when applicable, Medicaid when applicable, Tier 1 commercial payers, managed-care plans and master tracker.

WHILE PAYERS PROCESS

EHR/PM setup, clearinghouse, EDI, EFT, ERA, billing workflows, scheduling guidance and reporting. Do not sit idle waiting for credentialing.

BEFORE SCHEDULING OPENS

Confirm payer status, provider status, expected effective dates, scheduling rules, billing readiness and patient financial policies.

BEFORE GO-LIVE

Run the bookend test: can claims go out, and can payments come back? Review every unresolved Tier 1 payer.

AFTER GO-LIVE

Continue payer follow-up, claim rejection and denial monitoring, A/R review, payer additions and payer-mix analysis using real practice data.

PARALLEL TRACKS SAVE TIME

Credentialing, technology setup, billing workflow and scheduling readiness should progress together. Waiting for one track to finish before starting the next can unnecessarily delay the launch.

YOUR FIRST PAYER LIST SHOULD EVOLVE

Do Not Over-Credential Before You Have Data

Six months after launch, you will know things you could not know on day one. A payer may represent far more volume than expected. Another may barely appear. A nearby employer may create new demand. A plan may reimburse poorly or create more administrative friction than anticipated.

USE THE DATA

Credentialing should support the business strategy. The business strategy should not be built around collecting as many payer contracts as possible.

The new-payer test

1	Do our patients actually have this plan? Evidence beats assumptions.
2	Will it produce meaningful volume? Every payer contract creates ongoing administrative work.
3	Does the reimbursement make sense? Volume alone is not enough.
4	Is it important to our referral strategy? Some payer relationships matter beyond direct volume.
5	Do we have the capacity to manage it well? More payer rules are not automatically better.

IF THIS SOUNDS LIKE A LOT TO BUILD WHILE YOU ARE ALSO OPENING A PRACTICE, IT IS.

AMS can take over the credentialing and payer-enrollment work after your legal entity is formed - including payer research, prioritization, applications, follow-up and status reporting.

THE TRAPS THAT CREATE AVOIDABLE DELAYS

Common New-Practice Credentialing Mistakes

STARTING TOO LATE

Credentialing begins when the office is almost ready. The practice opens before payer enrollment catches up.

APPLYING TO EVERY PAYER

Resources get spread across low-value plans instead of focusing on the networks that actually matter.

ASSUMING EXISTING CREDENTIALS TRANSFER

A provider's existing payer relationship does not automatically establish the new organization, location or group affiliation.

TREATING SUBMISSION AS COMPLETION

An application without follow-up is only an application.

IGNORING EFT / ERA / EDI

The practice is credentialed but cannot efficiently submit claims, receive payments or reconcile remittances.

SEPARATING CREDENTIALING AND BILLING

Credentialing knows a payer is effective while billing does not - or scheduling assumes a payer is active when it is not.

NO REASON FOR THE PAYER

Nobody can explain why a plan is on the list beyond "we thought we should take it."

NO CLEAR OWNER

Open tasks have no next action, follow-up date or accountable person.

PAUSE WHEN THE STRATEGY GETS FUZZY

If nobody can explain why the practice is pursuing a payer, stop. Credentialing resources should follow the business strategy.

BUSINESS, PROVIDER AND PAYER READINESS

New Practice Launch Checklist

BUSINESS FOUNDATION

- ☐ Legal entity formed
- ☐ EIN / tax information available
- ☐ Business bank account established
- ☐ W-9 available
- ☐ Organizational NPI obtained
- ☐ Practice address established
- ☐ Ownership information available

PROVIDER FOUNDATION

- ☐ Individual NPI confirmed
- ☐ Licenses confirmed
- ☐ DEA confirmed if applicable
- ☐ Malpractice established
- ☐ CV / work history available
- ☐ CAQH reviewed
- ☐ Required documents collected

PAYER STRATEGY

- ☐ Target patient population identified
- ☐ Major local commercial plans researched
- ☐ Medicare strategy determined
- ☐ Medicaid strategy determined
- ☐ Managed-care plans researched
- ☐ Medicare Advantage plans researched
- ☐ Major employer plans considered
- ☐ Referral-network needs considered
- ☐ Competitor participation reviewed
- ☐ Tier 1 payer list created
- ☐ Tier 2 payer list created
- ☐ Low-priority payers intentionally deferred

CREDENTIALING, INFRASTRUCTURE AND GO-LIVE

New Practice Launch Checklist

CREDENTIALING

- ☐ Medicare submitted if applicable
- ☐ Medicaid submitted if applicable
- ☐ Tier 1 commercial applications submitted
- ☐ Provider affiliations tracked
- ☐ Contracts tracked
- ☐ Follow-up dates documented
- ☐ Effective dates confirmed

REVENUE-CYCLE INFRASTRUCTURE

- ☐ EHR / PM configured
- ☐ Clearinghouse configured
- ☐ EDI enrollments completed
- ☐ EFT enrollments completed
- ☐ ERA enrollments completed
- ☐ Payer IDs confirmed
- ☐ Providers loaded correctly
- ☐ Locations loaded correctly
- ☐ Claim workflow tested
- ☐ Payment-posting workflow established

GO-LIVE READINESS

- ☐ Active payer list distributed
- ☐ Pending payer list distributed
- ☐ Scheduling team educated
- ☐ Billing team educated
- ☐ Held-claim process established if needed
- ☐ Timely-filing limits monitored
- ☐ Credentialing escalation process established
- ☐ A/R reporting prepared
- ☐ Denial reporting prepared

THE FINAL LEADERSHIP CHECK

Five Questions to Answer Before You Open

1	Who are our five most important payers? If the answer is "we applied to everybody," go back and do the market research.
2	Which payers are actually active today? Not submitted. Not almost done. Active.
3	Can we send claims? Run the workflow before real revenue depends on it.
4	Can we receive and post payments? Do not forget the other bookend.
5	Who owns everything that is still open? Every unresolved item needs an owner, a next step and a follow-up date.

IF THIS SOUNDS LIKE TOO MUCH, LET OUR TEAM HANDLE IT FOR YOU.

Once your LLC, corporation or other legal entity has been formed, AMS Solutions can take the credentialing process from there.

We can help research and prioritize payers, build provider files, manage Medicare and Medicaid enrollment, handle commercial applications, track contracting and group affiliations, follow up with payers, monitor effective dates and coordinate credentialing with billing readiness.

You build the practice. We will help build the payer infrastructure behind it.

REFERENCE FRAMEWORK

Sources & Methodology

This guide is an operational planning resource, not a payer-specific enrollment manual or legal, tax or contracting opinion. Payer requirements, network availability, reimbursement, credentialing processes, effective-date rules and processing times vary by health plan, state, provider type and market.

Centers for Medicare & Medicaid Services - NPI Fact Sheet
CMS explains Type 1 and Type 2 NPIs and notes that having an NPI does not itself credential a provider, enroll the provider in a health plan or guarantee payment.
https://www.cms.gov/files/document/npi-fact-sheet.pdf

Centers for Medicare & Medicaid Services - PECOS / Manage Your Enrollment
CMS describes PECOS as the online Medicare enrollment management system and explains that Medicare Administrative Contractors process enrollment applications for providers and group practices.
https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/manage-your-enrollment

Centers for Medicare & Medicaid Services - Enrollment Applications
CMS identifies the CMS-855B for clinics and group practices, the CMS-855I for physicians and non-physician practitioners, and the CMS-588 EFT authorization used with Medicare enrollment.
https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/enrollment-applications

CAQH - Provider Data Portal
CAQH describes provider, practice-manager and group tools that support sharing provider and practice information for credentialing, directories and selected enrollment functions.
https://www.caqh.org/hubfs/CAQH-Provider-Data-Portals-Overview.pdf

Medicaid.gov - Managed Care Enrollment Report
CMS publishes plan-specific and state-level Medicaid managed-care enrollment data, including plan names, geographic areas and enrollment counts.
https://www.medicaid.gov/medicaid/managed-care/enrollment-report

CMS - Medicare Advantage / Part D Contract and Enrollment Data
CMS publishes monthly plan and county-level Medicare Advantage enrollment data that can be useful when evaluating the payer landscape in a market.
https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data

CMS - EFT and Electronic Remittance Advice
CMS explains EFT and ERA transactions and encourages providers to enroll in both with participating health plans to support payment and reconciliation workflows.
https://www.cms.gov/priorities/key-initiatives/burden-reduction/administrative-simplification/operating-rules/eft-remittance-advice

Prepared by

Brad Becker, CRCR
Regional Billing Manager
AMS Solutions

ABOUT AMS SOLUTIONS

AMS Solutions provides medical billing, revenue-cycle management and provider credentialing support for medical practices. Visit ams-solutions.com or call 866-973-2221.

AMS SOLUTIONS

Ready to talk it through?

Every practice's payer mix and timeline is different. Tell us about your providers, payers and start dates, and our credentialing team will walk through what it will take to get everyone enrolled and billing.

Free and no obligation. Complete a short form and a member of our team will follow up.

Request a Consultation →

Click the button above to open the request form.

Prefer to call? 866-973-2221 · info@ams-solutions.com