AMS Solutions
A SUPERIOR MEDICAL BILLING SERVICE

We Hired a New Provider. Now What?

A credentialing & enrollment guide for medical practices

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NEW PROVIDER CREDENTIALING GUIDE

FROM SIGNATURE TO BILLING READY

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You hired the provider. The offer letter is signed. The start date is on the calendar. The practice is preparing the schedule.

What needs to happen before we can bill insurance for this provider under our practice?

Hiring a provider and adding that provider to your payer contracts are two different processes. A clinician may already have an NPI, maintain an active CAQH profile, participate with Medicare, and be credentialed with several commercial payers - and still not be ready to bill under your group.

THE CORE QUESTION

Is this provider properly connected to this practice for this payer? That is the question the onboarding process must answer.

FIRST, SEPARATE THE MOVING PARTS

What "Credentialed" Actually Means

Credentialing conversations become confusing because several related processes are often described using the same word. They are connected, but they are not interchangeable.

NPI

A National Provider Identifier identifies an individual provider or organization. Individual providers generally use a Type 1 NPI; organizations and group practices generally use a Type 2 NPI. An NPI does not mean the provider is enrolled or credentialed with a payer.

CREDENTIALING

The payer or organization verifies professional qualifications such as licensure, education, training, malpractice coverage, work history and other required information.

ENROLLMENT

The provider is established with a payer so services can be billed and processed according to that payer's requirements.

GROUP AFFILIATION / REASSIGNMENT

The payer recognizes the relationship between the individual provider and your practice. For Medicare, this may involve reassignment of benefits to an enrolled organization. Commercial payers use different terminology and processes.

THE MOST COMMON MISUNDERSTANDING

"The provider is already credentialed." Great - but that does not automatically mean the provider is ready to bill through your group. Existing payer relationships may be tied to another practice, location or billing arrangement.

That is why credentialing should begin before the provider's first day whenever possible. The goal is not simply to verify the provider. The goal is to connect the provider, the practice, the location and the payer correctly before claims begin flowing.

STEPS 1-3

Build the Foundation Before You Apply

1 Build the Provider File

Collect the core information and documents once, then use that complete file intelligently across payer applications. Chasing the same document separately for every payer wastes time and creates preventable delays.

- Full legal name and contact information
- Date of birth and SSN
- Individual NPI and taxonomy
- Professional license information
- DEA registration, when applicable
- CAQH information
- Medicare / Medicaid information, when applicable
- Education and training history
- Work history and gap explanations when required
- Board-certification information
- Malpractice coverage
- CV and supporting certificates
- Group NPI, TIN, locations and W-9
- Provider start date and practice contacts

2 Review NPPES

Do not assume the NPI record is accurate simply because an NPI exists. Review legal name, taxonomy, mailing information, practice information and other relevant data. Remember: updating NPPES does not automatically update every payer or Medicare enrollment record.

3 Review CAQH

For many commercial plans, CAQH is a core piece of the credentialing file. Review demographics, licenses, malpractice coverage, education, work history, practice information, supporting documents, authorizations and attestation status before payer submissions begin.

THE GOAL

Create a clean, complete provider file first. A strong foundation makes every payer application easier; a weak foundation multiplies the same problem across every application.

STEP 4

Build the Payer Map

Now determine exactly which payers the provider needs. Do not simply apply everywhere. Start with the plans that matter to the practice and the population the provider will actually see.

• Medicare	• State Medicaid
• Medicaid managed-care plans	• Major commercial plans
• Medicare Advantage plans	• Specialty-specific networks
• Workers' compensation or other relevant programs	• Any payer important to the practice's current patient population

Then create a payer-by-payer tracker. For each payer, answer the following:

☐ Is the group already participating?	☐ Is the provider already participating?
☐ Does the provider need individual credentialing?	☐ Does the provider need to be affiliated with the group?
☐ Is a roster submission sufficient?	☐ Is a complete application required?
☐ Does the payer require contracting?	☐ Are additional documents needed?
☐ Has the application been submitted?	☐ What is the confirmed effective date?
☐ Is the provider actually loaded into the payer's system?	☐ Who owns the next action?

DO NOT STOP AT "APPROVED"

Approval on paper and readiness in the payer's claims system are not always the same moment. The real operational finish line is knowing the provider is configured correctly for billing under your group.

STEPS 5-6

Medicare and Medicaid Need Their Own Workflows

5 Handle Medicare Correctly

Medicare enrollment information is managed through PECOS. When an eligible practitioner will bill through a Medicare-enrolled organization, the appropriate reassignment relationship must also be established. The operational question is not simply, "Does this provider have Medicare?" It is: Is this provider properly enrolled and connected to our Medicare group?

MEDICARE CHECK

Confirm the individual enrollment, the organization enrollment, the reassignment relationship, the appropriate practice location and the effective date before treating the provider as billing ready.

6 Review Medicaid Separately

Medicaid is state-specific and should not be treated as an extension of Medicare. Depending on the state and payer structure, the provider may need state Medicaid enrollment, group affiliation, managed-care enrollment, location additions or other state-specific actions.

A provider who was enrolled with Medicaid through another organization may still require updates or affiliations before billing through your practice. If Medicaid represents a meaningful portion of your payer mix, address it early.

PRACTICAL RULE

Do not let the phrase "they already have Medicaid" end the conversation. Verify the relationship that matters for your group, your location and your billing arrangement.

STEP 7

Commercial Payers: Manage Them Payer by Payer

Commercial payer requirements vary substantially. One payer may require a full credentialing application. Another may use CAQH. Another may accept a roster. Another may require a provider-add form, contract amendment or additional participation agreement.

The requirement can also change based on provider type, specialty, location, state, existing group contract or payer product.

FULL CREDENTIALING	CAQH-DRIVEN
Provider completes the payer's full credentialing workflow.	Payer relies heavily on the provider's CAQH profile and supporting documentation.
ROSTER ADD	**PROVIDER-ADD FORM**
Existing group submits the provider through a payer roster or standardized addition process.	Payer uses a specific form to connect the provider to the existing group.
CONTRACT ACTION	**LOCATION ACTION**
Provider addition may require an amendment, participation document or other contracting step.	The provider may need to be added to or linked with the correct service location.

THERE IS NO UNIVERSAL BUTTON

There is no reliable button labeled "Add this provider to every insurance company." Credentialing would be a much calmer profession if there were. The safest model is payer-by-payer ownership and tracking.

STEP 8

Submitting the Application Is the Beginning

Every payer application should have a clear status. The exact labels can vary, but leadership should be able to tell what is happening without decoding a spreadsheet full of vague notes.

NOT STARTED Information or documents are still needed.	**READY TO SUBMIT** The provider file is complete for this payer.	**SUBMITTED** The payer has received the application.
PENDING The payer is actively processing the application.	**ADDITIONAL INFO REQUESTED** The payer needs something before processing can continue.	**APPROVED** The payer has approved the provider or requested action.
EFFECTIVE DATE CONFIRMED The payer has confirmed when participation or affiliation becomes effective.	**LOADED / BILLING READY** The provider is correctly established for the intended billing workflow.	**ESCALATION NEEDED** The application is stalled, inconsistent or outside the expected path and needs targeted follow-up.

"PENDING" IS NOT A CREDENTIALING STRATEGY

If an application has been pending for weeks, ask: When was it submitted? Was receipt confirmed? Is it complete? Has additional information been requested? When was the last follow-up? Is there a case number? What is the next action? Who owns it?

PROTECT THE REVENUE BEFORE THE SCHEDULE FILLS

The Start Date Is Not Necessarily the Billing Date

A provider's employment start date and payer effective date are not automatically the same. A provider may be ready for onboarding, EHR training and clinical orientation while payer enrollment is still being completed.

BEFORE SCHEDULING INSURED PATIENTS

Understand the provider's status with the applicable payer. Seeing the patient and getting paid correctly for the visit are two different questions.

Should we hold claims until credentialing is complete?

Sometimes - but that should never become the automatic strategy without understanding payer rules, effective dates, timely-filing limits, retrospective-billing policies, provider status and contract requirements.

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

IF THIS SOUNDS LIKE A LOT TO MANAGE, IT IS.

You do not have to build and manage this process internally. AMS Solutions can handle provider onboarding, payer enrollment, group affiliations, follow-up and status reporting for you - so your team can focus on getting the provider operational and caring for patients.

FINISH THE LAST MILE

Credentialing Does Not End at the Approval Email

When approval arrives, verify what was actually approved. Do not let the approval email become the finish line if the operational setup is incomplete.

☐ Provider identity	☐ Group / billing entity
☐ Service location	☐ Effective date
☐ Network or product	☐ Billing information
☐ Any payer-specific limitations	☐ Whether the billing team can confirm readiness

Then make sure the information reaches the people who need it: billing, scheduling, front desk, practice management, coding and the provider.

OPERATIONAL INFORMATION, NOT CREDENTIALING-DEPARTMENT INFORMATION

If billing does not know the provider became effective, claims may remain held unnecessarily. If scheduling assumes participation before confirmation, the opposite problem occurs. Credentialing status needs to move across the practice.

What if the provider is already with the same payers?

Good. That can make portions of the process easier, but it does not eliminate the need to verify the relationship with your organization. Never confuse participating with the payer with participating with the payer through our group.

What if the provider works at multiple practices?

That is not inherently unusual. Providers can have multiple practice relationships, but your organization still needs its own group affiliation, location, billing arrangement, participation and effective-date details configured correctly.

TIMING MATTERS

Start Early - and Know the Red Flags

Once the provider's start date is sufficiently firm and you have the information necessary to begin, credentialing should move. Processing times vary by payer, provider type, market and application completeness, so a single universal timeline is not reliable.

WORK BACKWARD FROM THE START DATE

Do not wait until the provider arrives to begin. The best credentialing delay is the one your practice never creates.

"They are already credentialed, so we are good."	Maybe. Verify the payer relationship with your group.
"We submitted everything. Now we just wait."	Submission without follow-up is not credentialing management.
"Everything is pending."	Pending with whom? Since when? For what reason?
"We will just bill it once they start."	That can create denials, filing-limit exposure and avoidable A/R.
"Billing will figure it out."	Billing cannot manufacture payer enrollment after the claim denies.
"The payer approved them."	Great. What is the effective date, group, location and product? Finish the last mile.

PROVIDER + PRACTICE READINESS

New-Provider Credentialing Checklist

PROVIDER READINESS
☐ Individual NPI confirmed
☐ Professional licenses verified
☐ DEA information collected if applicable
☐ CAQH access confirmed
☐ CAQH profile reviewed
☐ Malpractice information collected
☐ CV / work history collected
☐ Board information collected
☐ Education and training information collected
☐ Provider contact information confirmed
☐ Required supporting documents collected

PRACTICE READINESS
☐ Legal business name confirmed
☐ Tax ID confirmed
☐ Group NPI confirmed
☐ Practice locations confirmed
☐ Billing information confirmed
☐ W-9 available
☐ Group payer contracts reviewed
☐ Provider start date confirmed
☐ Billing contact identified
☐ Credentialing contact identified

USE THIS BEFORE APPLICATIONS GO OUT

If either column has major gaps, fix the foundation before multiplying those gaps across multiple payer submissions.

FROM PAYER MAP TO BILLING READY

Payer Plan + Application Management Checklist

PAYER PLAN
☐ Medicare reviewed
☐ Medicaid reviewed
☐ Medicaid managed-care plans reviewed
☐ Major commercial payers identified
☐ Medicare Advantage plans reviewed
☐ Other relevant payers identified
☐ Existing provider participation researched
☐ Required group affiliations identified
☐ Applications / rosters identified

APPLICATION MANAGEMENT
☐ Application submitted
☐ Submission date documented
☐ Confirmation / reference number documented
☐ Follow-up date scheduled
☐ Additional requests tracked
☐ Approval documented
☐ Effective date documented
☐ Group affiliation verified
☐ Location verified
☐ Billing team notified
☐ Provider released for the appropriate scheduling / billing workflow

Five questions to ask before the provider's first day

1	Which payers is the provider completely ready to bill?
2	Which payers are still outstanding?
3	What is preventing each outstanding payer from being completed?
4	What happens to patients scheduled with those plans?
5	Who owns every remaining credentialing task?

BUILD AN OPERATIONAL ONBOARDING SYSTEM

The Goal Is Not to Submit Applications

The goal of provider credentialing is not to submit a stack of forms. The goal is to get the provider correctly established with the payers your practice needs so eligible services can be billed and paid appropriately.

A strong provider-onboarding process connects four teams:

CREDENTIALING	OPERATIONS	SCHEDULING	BILLING
Enrolls and affiliates the provider appropriately.	Knows when and where the provider will practice.	Knows which patients can appropriately be placed on the schedule.	Knows when claims can flow and what payer issues remain.

THE SIMPLEST WAY TO THINK ABOUT IT

WHO ARE THEY? NPI, licenses, professional information and CAQH.
WHERE ARE THEY PRACTICING? Group, tax ID, locations and organizational information.
WHO NEEDS TO RECOGNIZE THE RELATIONSHIP? Medicare, Medicaid, commercial plans and other relevant payers.
WHEN CAN WE BILL? Confirmed effective dates, group affiliations and payer readiness.

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

Provider onboarding is detail-heavy, payer-specific and time-sensitive. AMS Solutions can manage the credentialing workflow from the provider file through payer enrollment, group affiliation, follow-up and status reporting.

One provider or an entire clinical team - we can build the payer map, manage the applications and keep your practice informed until the provider is ready to bill.

Talk with AMS Solutions about credentialing and provider enrollment support.

REFERENCE FRAMEWORK

Sources & Methodology

This guide is an operational resource, not a payer-specific enrollment manual. Credentialing terminology, documents, participation requirements, effective-date rules and processing timelines vary by payer, provider type, state and market. Practices should verify requirements with the applicable payer.

Centers for Medicare & Medicaid Services - National Provider Identifier (NPI): What You Need to Know
CMS explains that obtaining an NPI does not enroll a provider in a health plan, ensure credentialing, replace Medicare enrollment, or guarantee payment.
https://www.cms.gov/files/document/icn902603npibookletpdf

Centers for Medicare & Medicaid Services - Manage Your Enrollment / PECOS
CMS describes PECOS as the online Medicare enrollment management system for enrolling, updating, revalidating and managing enrollment information.
https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/manage-your-enrollment

CMS Fee-For-Service Public Provider Enrollment Methodology
CMS enrollment data documents practitioner-to-organization reassignment relationships and practice-location information maintained through PECOS.
https://data.cms.gov/resources/fee-for-service-public-provider-enrollment-methodology

CAQH Provider Data Portal
CAQH describes provider, practice-manager and group tools used to maintain and share professional, practice, credentialing, directory and selected enrollment information.
https://www.caqh.org/hubfs/CAQH-Provider-Data-Portals-Overview.pdf

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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