

Early Steps Provider Review Checklist

Provider Demographics:

First Name: _____ MI: _____ Last Name: _____

SS#: _____ DOB: ____/____/____

Received: ____/____/____

Determination: Approved / Denied / Withdrawn on ____/____/____

Application Review and Credential Verification	Verification Source
<input type="checkbox"/> OIG Exclusions List: Yes / No Exclusions List	If yes, do not move forward. Provider ineligible for credentialing. http://exclusions.oig.hhs.gov/
<input type="checkbox"/> W9(s): Yes / No Criminal Activity Reported: Yes / No Complaints / Liabilities Reported: Yes / No	Explanation
<input type="checkbox"/> License #: _____ Controlled Subs: Yes / No Disciplinary Action: Yes / No Complaint: Yes / No MQA Status: _____ State: _____ Expires: ____/____/____ If explanation of actions needed: Explanation Received: ____/____/____	State Medical Quality Assurance (MQA) - Allowable states: Alabama, Georgia, North Carolina MQA: Use Fire Fox as browser https://appsmqa.doh.state.fl.us/IRM00PRAES/PRASLIST.ASP Explanations via fax/mail/email, if applicable
<input type="checkbox"/> National Provider ID Match: Yes / No: _____ NPI Taxonomy Match: Yes / No: _____	National Plan & Provider Enumeration System NPPE: https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do
<input type="checkbox"/> Professional Liability Claims (prev. 5yrs): Yes / No # of claims reported: _____ # of claims found: _____ Claims explained: Yes / No Proof of Malpractice/Liability Insurance	Dept. of Insurance PLCR: https://apps.fldfs.com/PLCR/Search/MPLClaim.aspx Copy of Liability Insurance Coverage (Group or Solo)
<input type="checkbox"/> Curriculum Vitae (prev. 5 years, mo/year timeline): Yes / No Gaps of >90days: Yes / No	Explanation of Gaps
<input type="checkbox"/> Degree _____ Name of University _____	Confirmation of university accreditation https://ope.ed.gov/accreditation/Search.aspx
<input type="checkbox"/> Medicaid Number (9-digit): _____ FLMMIS: Active / Not Found / Other: _____ Eligible: Yes / No Level II: Pass / Fail	FLMMIS: https://sso.flmmis.com/adfs/ls/?wa=wsignin1.0&wtrealm=https%3a%2f%2fssso2.flmmis.com%2fadfs%2fis%2fid&wctx=c34ffc77-92af-43cc-82b6-e8b23761a033&wct=2016-01-15T19%3a31%3a04Z&whr=https%3a%2f%2fssso.flmmis.com%2fadfs%2fis%2fid AHCA: https://apps.ahca.myflorida.com/SingleSignOnPortal/Login.aspx?ReturnUrl=%2fSingleSignOnPortal
Early Steps/Early Intervention	
<input type="checkbox"/> ES Training Modules 1-3 Complete: Yes / No	Must have completed all three modules.
<input type="checkbox"/> ITDS Training Modules 1-6 Complete: Yes/No	Must have completed all 6 module or University coursework equivalent
<input type="checkbox"/> Reported ES Experience: Yes / No ES Mentorship Form: Yes / No	If no, completed ES Mentorship Form required.
Summary of Missing Information: Request Sent: ____/____/____	1. _____ Received: ____/____/____ 2. _____ Received: ____/____/____ 3. _____ Received: ____/____/____

Reviewer: _____ Date Reviewed: ____/____/____

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	4. _____	Received: ___/___/___
	5. _____	Received: ___/___/___

***Once approved – Provider can be entered into Early Steps Data System**

Reviewer: _____ Date Reviewed: ___/___/___