

Michigan Medicaid Health Plan Standardized Credentialing Definitions & Instructions

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Beginning October 1, 2026, the Michigan Department of Health and Human Services (MDHHS) and Michigan's Medicaid Health Plans (MHPs) are implementing changes to how individual providers share information for credentialing and plan enrollment. These changes are intended to reduce administrative burden, improve timeliness, and standardize credentialing and enrollment processes across Michigan's MHPs.

This document is intended to serve as a comprehensive resource for individual providers seeking to join one or more MHP networks and outlines:

- Instructions for how to participate in the standardized credentialing and plan enrollment process;
- What information to submit to MHPs;
- What to expect once the information has been submitted

1. Scope & Applicability

This document applies to MHP enrollment and credentialing of activities for:

- Individual practitioners (e.g., MD/DO, NP, PA, behavioral health clinicians)
- Atypical providers as defined by MHP contracts and state/federal requirements

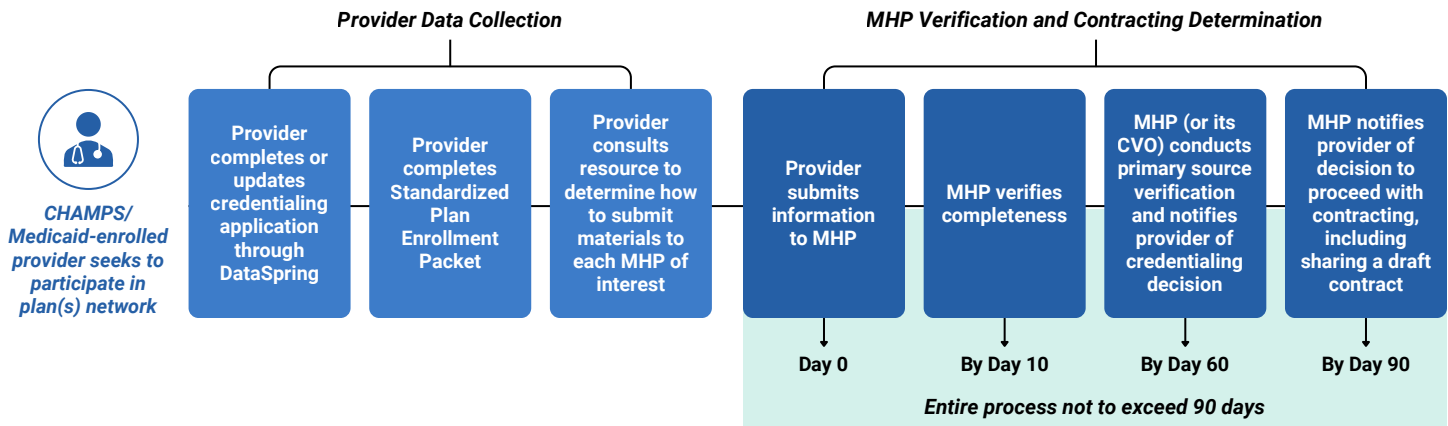
Note: This document is designed to standardize definitions and workflow steps. It does not replace regulatory, accreditation, or contractual requirements. This process does not apply to delegated arrangements (see section 3.11 in this document for more information).

2. Instructions to Participate in the Standardized Credentialing and Plan Enrollment Process

Providers should:

- Enroll in [CHAMPS](#) if they have not done so already
- Complete a [DataSpring \(formerly CAQH\) for Clinicians](#) form if applicable, described in section 3.6 of this document
- Complete the plan enrollment materials described in section 3.6 of this document
- Submit a complete DataSpring profile (*if applicable*) and plan enrollment packet to each MHP the provider is seeking to contract with
- MHPs will notify providers within 10 calendar days of submission if their application packet was deemed incomplete

See a visual depiction of this process here.



3. Standardized Definitions (Credentialing Terminology)

3.1 Credentialing

Credentialing is the process of collecting, verifying, and evaluating provider qualifications to confirm they meet minimum standards for participation in an MHP network.

Credentialing typically includes (as applicable):

- Education and training verification
- Licensure verification
- Board certification (if applicable)
- Work history review
- Sanctions and exclusion screening
- Malpractice claims history review- including running/reviewing National Practitioner Data Bank (NPDB) report
- Current malpractice insurance

3.2 Recredentialing

Recredentialing is the periodic review of a provider's qualifications after initial credentialing to ensure ongoing compliance with participation requirements not to exceed 36 months.

3.3 Credentialing Entity

The Credentialing Entity is the organization responsible for credentialing decisions, which may include:

- The Medicaid Health Plan (MHP)
- A delegated provider organization (e.g., health system)

3.4 Credentialing Verification Organization (CVO)

A CVO is an organization that performs credentialing functions (e.g., primary source verification, screening, file assembly), either directly for an MHP or under delegation.

3.5 Primary Source Verification (PSV)

Primary Source Verification (PSV) means obtaining verification of a credential directly from the original source (or an approved, authoritative intermediary database), including but not limited to:

- State licensing board verification for active license status
 - NPDB query
 - DEA status verification (*if applicable*)
 - Board certification verification
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3.6 Credentialing Application Packet

A Credentialing Application Packet is the full set of documents required to begin credentialing and determine application completeness.

It includes:

1. **Uniform Provider Enrollment Form or Provider Enrollment Excel Roster for large practices** (*five or more providers*)
 - a. This is the form to initiate the credentialing process and includes information necessary to enroll in the network, if the MHPs decide to contract with the provider or practice. Completion of this form does not guarantee a contract will be granted.
 2. **DataSpring Provider Data Portal, previously Council for Affordable Quality Healthcare (CAQH)** (*if applicable*)
 3. **Agreements/Contracts**
 - a. Some MHPs may require a signed contract prior to submission of a credentialing application. Please check the MHP(s) website for contract requirements before submitting the credentialing application.
 4. **Required attestations, dates, and signatures**
 - a. CSHCS Attestation (*if applicable*)
 - b. Cultural Competency Attestation
 5. **Any standardized supplemental forms**
 - a. W9
 - b. Practitioner Enrollment Disclosure Questions (*for Non-CAQH-enrolled providers*)
 - c. Collaborating/Supervision Physician Agreement (*if applicable*)
 - d. Practicing Locations Form (*if multiple locations*)
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3.7 Complete Application (*Standard Definition: What is needed for Credentialing*)

To be considered complete, the Plan Enrollment Packet must include:

1. A completed, signed, and dated Plan Enrollment Form authorized by MDHHS and maintained by the designated entity;
2. All supplemental forms as listed on Plan Enrollment Packet instructions.

A completed enrollment form MUST:

- Be signed and dated (as required). Blue Cross Complete and Upper Peninsula Health Plan will accept only the Provider Enrollment Form signed by the Provider; all other Plans will accept the signature of the Provider or Authorized Representative.
- Include all mandatory fields populated

A completed enrollment form MUST (cont.):

- Include all required supporting documents
 - Include current, accurate practice location(s) (if multiple locations, use additional Practicing Locations Form)
 - Include all required licensing and identification numbers
 - Non-CAQH Providers must complete the disclosure questions form
 - MHPs will notify providers within 10 calendar days of submission whether their application packet was deemed incomplete
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3.8 Incomplete Application

An Incomplete Application is missing required information or documentation and cannot advance to verification and committee review.

Examples of incompleteness:

- Missing signature/attestation- Signature dates to be current through the credentialing committee meeting date
 - Missing required license information or NPI
 - Missing malpractice coverage evidence (*if required*)
 - Missing work history gaps explanation (*if required*)
 - Missing documentation required for the provider type- Need to know the supervisor for a mid-level provider
 - MHPs will notify providers within 10 calendar days of submission whether their application was deemed incomplete
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3.9 Provisional Credentialing

Provisional Credentialing is a time-limited participation status that may allow a provider to serve members while final credentialing is completed, provided the provider meets minimum screening requirements.

Provisional credentialing may be granted only if a plan does not make a credentialing decision within thirty (30) calendar days and will be granted for no more than sixty (60) calendar days. Provisional credentialing is optional for MHPs and must include, at a minimum:

- Identity verification
 - A current and signed application with attestation (CAQH)
 - Active licensure verification
 - Sanctions/exclusion checks
 - History of Malpractice (e.g., no disqualifying adverse history)
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3.10 Final Credentialing Decision

The Final Credentialing Decision is the formal determination by the credentialing entity that the provider meets or does not meet the applicable credentialing standards, following completion of all required verifications and reviews under the credentialing entity's policies.

3.11 Delegation

Delegation is the process by which an organization authorizes another entity (e.g., provider organization, IPA, CVO, health system, vendor) to perform specified functions on its behalf.

While an organization may delegate authority to perform a function, it retains full accountability and oversight to ensure the function is completed accurately, on time, and in compliance with all applicable requirements.

Instruction: Please refer to your Plan Agreement to confirm whether your organization is subject to delegated credentialing and applicable delegation requirements.

4. Standard Credentialing Timelines (Uniform Targets)

4.1 Completeness Validation Timeline

Within 10 calendar days from receipt of the application packet, the Credentialing Entity must validate whether the application is complete.

Validation outcomes:

-  **Complete:** start verification and credentialing processing
 -  **Incomplete:** issue deficiency notice to provider
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4.2 Provisional Credentialing Timeline

Within 30 business calendar days of receiving a complete application packet, the Credentialing Entity may:

- Issue approval,
 - Grant provisional credentialing, OR
 - Continue current review without provisional credentialing, not to exceed sixty (60) calendar days
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4.3 Final Credentialing Decision Timeline (Does Not Include Contracting Timeline)

Within 60 calendar days of receiving a complete application packet, the Credentialing Entity must issue:

- Final approval, OR
 - Final denial, OR
 - Provide written notice of delay with reason and expected decision date (only permitted for exceptions)
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4.4 Decision to Contract

Within 90 calendar days of receiving a complete application packet, the Credentialing Entity must:

- Notify providers of intent to proceed with contracting
- Provide a draft contract