Provider Credentialing Timeline Template

A phase-by-phase plan to enroll a new provider or new payer without 90-day stalls

Credentialing fails on the calendar, not the paperwork. Most delays trace back to a missing document at submission or a follow-up call that nobody made in week 3. Use this template to map every phase, set follow-up dates before you submit, and hold realistic payer timelines so you can plan a start date you can actually bill against.

How to use this template

Copy the phases below into your own tracker (spreadsheet, practice-management task list, or credentialing software) and put a real date on every row. The single biggest predictor of an on-time effective date is whether someone owns the follow-up cadence -- not whether your packet was perfect on day one.

Work backward from a target start date. If a commercial payer commonly takes 90-120 days and you want a provider billing by October 1, your CAQH and documents need to be clean by early June. Build in 2-3 weeks of document-prep buffer before that.

Timelines below are general industry norms. Confirm each one against your own payers and state -- Medicaid and commercial timelines vary widely by plan.

Phase-by-phase timeline at a glance

This is the skeleton. The phases overlap on purpose: you can submit to fast payers while slow nationals are still in queue.

Phase	Typical duration	Key actions
1. Document and CAQH prep	2-3 weeks	Gather licenses, DEA, COI, NPI, education and work history; build or refresh CAQH ProView and attest
2. Payer application submission	1-2 weeks	Identify each payer's enrollment path; submit Medicare (PECOS), Medicaid, and commercial applications
3. Follow-up and verification	30-120 days	Confirm receipt within 7-10 days; call every 2-3 weeks; respond to primary-source verification requests within 48 hours
4. Committee and approval	varies by payer	Credentialing committee review, contract load, fee-schedule setup

Phase	Typical duration	Key actions
5. Effective date and go-live	1-2 weeks after approval	Confirm effective date in writing; check for retroactive billing window; release held claims

Phases 2 and 3 run in parallel across payers. Track each payer on its own row with its own follow-up dates.

Phase 1 -- Document and CAQH prep (before you start the clock)

Do not submit a single application until this checklist is complete. A packet missing one current document is the most common reason an application sits untouched for weeks before anyone tells you it is incomplete.

- [ ] NPI Type 1 (individual provider) confirmed and active in NPPES
- [ ] NPI Type 2 (organization/group) confirmed if you bill under a group
- [ ] CAQH ProView profile created or current, with the practice authorized to access it
- [ ] CAQH re-attested -- it must be re-attested every 120 days or it goes stale and payers cannot pull it
- [ ] State medical or dental license(s) current, with expiration dates noted
- [ ] DEA registration current (and state CDS registration where required)
- [ ] Malpractice certificate of insurance (COI) showing current coverage limits and dates
- [ ] Education and training history with no unexplained gaps (degrees, residency, fellowship)
- [ ] Complete work history, month and year, with explanations for any gap over 30 days
- [ ] Board certification status and any specialty documentation
- [ ] Government-issued photo ID, signed W-9, and voided check or bank letter for EFT setup
- [ ] Hospital admitting privileges or a documented coverage/admitting arrangement if required by the payer

Set every license, DEA, COI, and CAQH attestation as a recurring calendar reminder now. A COI that expires mid-review can reset your place in line.

Phase 2 -- Submit, payer by payer

Each payer has its own front door. Medicare runs through PECOS. Medicaid runs through your state's portal and rules. Commercial payers often pull from CAQH but still require a separate enrollment request and a contract.

- [ ] Make a one-row-per-payer list: payer name, product lines, submission method, date submitted, confirmation number
- [ ] Submit Medicare enrollment through PECOS (CMS-855I for individual, 855B/855R for group/reassignment)
- [ ] Submit Medicaid through the state portal; note the state's specific timeline and any in-state revalidation rules
- [ ] Authorize each commercial payer to access your CAQH profile and submit the enrollment request
- [ ] Record the confirmation or tracking number for every submission -- you will need it on every follow-up call
- [ ] Note whether each payer credentials and contracts in one step or two (many separate the two, which adds weeks)

Submitting is not enrolling. A payer can have your application and still not have started review. Confirm receipt before you count the clock as running.

Phase 3 -- The follow-up cadence that prevents stalls

This is where credentialing is won or lost. Applications do not stall because they were denied; they stall because they sat in a queue and nobody pushed. A fixed cadence turns a 120-day wait into a tracked process instead of a black box.

- Day 7-10: Call to confirm the application was received and is complete. Get a reference or case number.
- Every 2-3 weeks after: Call for a status update. Log who you spoke to, the date, and what they said.
- Within 48 hours: Respond to any request for additional information or primary-source verification. This is the fastest place to lose two weeks.
- At day 60 (Medicare/Medicaid) or day 90 (commercial): If there is no decision, escalate to a supervisor or your provider-relations rep.
- Keep a running contact log per payer -- names and dates are your leverage when a payer claims it 'never received' something.

If a payer says 'we never got it,' your dated confirmation number and call log are what get you re-queued without starting over.

Realistic payer timelines to plan against

Use these as planning anchors, then replace them with your own payers' actual numbers as you learn them. The clock typically starts at a clean, complete application -- not at the day you first hit submit.

Payer type	Typical timeline	Planning notes
Medicare (PECOS)	60-90 days	Effective date can be retroactive; ask about the retro window
Medicaid	Varies widely by state	Some states 30-60 days, others 90-120+; check your state portal's stated norm
Commercial (general)	90-120+ days	Credentialing plus separate contract load adds time
Blue Cross / Blue Shield plans	Often near 90 days	State-by-state plans; timelines differ by local Blue
Large national carriers	120+ days	Highest-volume queues; start these first and follow up hardest

These are general norms, not guarantees. A single missing document or a backlogged committee can add weeks to any of them.

Phase 5 -- Effective date, go-live, and retroactive billing

Approval is not the finish line -- the effective date is. The effective date determines the first day you can bill that payer for that provider, and it is not always the date the letter arrives.

- ☐ Get the effective date for each payer in writing, per product line
- ☐ Ask whether the effective date is retroactive to your application date and what the retroactive billing window is
- ☐ Confirm the provider is loaded in the payer's directory and linked to the correct group TIN and locations
- ☐ Verify the fee schedule loaded correctly before releasing claims
- ☐ Release any claims you held during credentialing, in date order, within the payer's timely-filing limit
- ☐ Update your clearinghouse and PM system with the new payer enrollment and effective date

Decide your hold-vs-bill policy up front. Holding claims until the effective date avoids denials, but only works if you stay inside each payer's timely-filing window.

Common stall points to design around

- Stale CAQH: a profile not re-attested in 120 days blocks payers from pulling it -- set the reminder now
- Work-history gaps: any unexplained gap over 30 days triggers a verification request and a delay
- Expired COI or DEA mid-review: a document that lapses during review can reset your place in line
- Group vs. individual confusion: missing the 855R reassignment or wrong Type 2 NPI stalls group billing
- Treating submission as completion: nobody confirmed receipt, so the clock never actually started
- No owner for follow-up: the application sits in a queue because no one on your side is assigned to push it

Compare credentialing and provider-enrollment services on GetPracticeHelp by specialty and payer.

This template is general informational content for practice-management planning, not legal, billing, or compliance advice. Credentialing requirements, effective-date rules, and retroactive billing windows vary by state, payer, and plan, and change over time. Confirm every timeline and requirement directly with each payer and with your own advisors before relying on it.