



Please provide the information requested below for credentialing purposes: (PCP must provide ALL requested information. Specialists and other facilities only require completed provider agreement and W-9)

_____ **MAHP/CAQH Application Completed (CCA does not subscribe to CAQH and will therefore need a complete copy of the CAQH summary.)**

_____ **Medical License**

_____ **DEA License**

_____ **Liability Insurance**

_____ **Completed Provider Agreement**

_____ **Completed W-9**

Under the rules and regulations governing the Wayne County Health Choice Program, Community Care Associates must have current copies of these documents in our files. Please forward the requested information to our confidential fax number at 313-961-3116 as soon as possible.

Thank you in advance for your cooperation.

Sincerely,

Credentialing Department